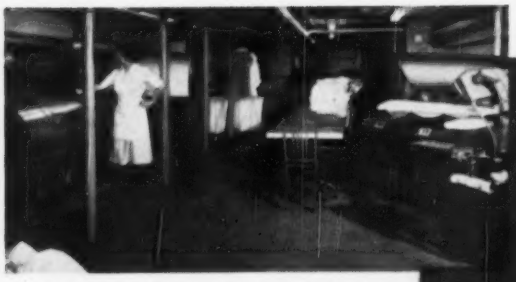
THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

NOVEMBER, 1950



▲ Efficient new laundry at Midwood Hospital includes CASCADE Washer, Solid Curb Extractor, gas-heated AIRCRAFT Tumbler, special Nurses Uniform Press Unit, and gas-heated Flatwork Ironer.

Congratulations to Midwood Hospital Brooklyn

...on its New, Compact, Well-Planned Laundry Department

▲ One operator completely machine-irons nurses uniforms at low cost on this special SUPER-ZARMO SUPER-ZARMOETTE Press Unit.

▲ Gas-heated AIRCRAFT Tumbler at Midwood Hospital quickly fluff-dries towels, bed pads, and similar items not ironed, to a downy softness. Heated with natural or artificial gas, AIRCRAFT Tumbler provides fast, low-cost drying for hospitals where high-pressure steam is unavailable. Tumbler features simple, safe operation and sturdy, lasting construction.

REMEMBER — *Every department of the hospital depends on the laundry.*

PROBLEM: Shortages in clean linens and uniforms frequently hampered the staff of this 60-bed hospital during week ends and holidays.

SOLUTION: Our Laundry Advisor was requested to plan a laundry that would provide a constant, plentiful supply of clean linens most economically. He carefully studied linen requirements of each hospital department and space available for the laundry. Then, he submitted equipment recommendations and detailed floor-plan for a laundry to meet the hospital's exact needs. Plans were approved and the equipment installed.

RESULTS: Hospital reports that speed and efficiency of new laundry has completely eliminated linen shortages. All hospital departments are always generously supplied with clean linens to meet any emergency. Low laundering costs and excellent quality of laundered linens and uniforms are especially appreciated.

Our Laundry Advisor is ready to assist you with any laundry problem. His services are free. WRITE TODAY.

Your hospital will benefit by selecting from our complete line of most advanced and productive hospital laundry equipment.

The

CANADIAN

LAUNDRY MACHINERY CO., LIMITED

47-93 STERLING ROAD, TORONTO 3, ONT.

WESTERN REPRESENTATIVES—Stanley Brock Limited
Winnipeg, Calgary, Edmonton, Vancouver.

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When the foods you serve are tempting, wholesome and packed with extra flavor—yet afford you real economy too—your food department is outstanding.

When you rely on Gumpert food products, you get that extra quality and economy in four ways: Finest, top-of-the-crop *ingredients*. Easiest, work-saving *methods*. Simple, accurate *cost control* that safeguards your budget. Standardization for perfect uniform *results* without waste.

Get quality food value for each dollar this year. Use Gumpert's famous food specialties and guarantee an outstanding food service department.

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OUTSTANDING QUALITY FOR HOSPITAL FEEDING

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- Extracts and Colors
- Cake Mixes
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- Complete Line of Bakery and Ice Cream Specialties
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S. GUMPERT CO. OF CANADA, LTD.

31 Brock Ave. • TORONTO, ONTARIO

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Contents

Volume 27 **NOVEMBER, 1950** No. 11

5 REASONS WHY

the **BAXTER Closed System** is an established, ***preferred*** method of blood banking...

no contact with outside air

With the BAXTER CLOSED SYSTEM, blood can be drawn and stored for a maximum period; or, plasma or serum can be prepared—all without risk of contamination from outside air.

controlled vacuum

BAXTER containers utilize mechanically induced vacuum to draw a large volume of blood into the bottle. This vacuum permits transfer of blood or plasma from one container to another, aseptically, without any break in the closed technique.

steady flow

During administration, air enters the container through an air tube. A steady flow of blood or solutions results, rather than intermittent gurgling.

faster and easier

The BAXTER method is a model of streamlined efficiency, simplicity, and safety, and can be brought into use instantly.

standardized technique

Because the BAXTER closed system is used in more hospitals than any other method, most nurses are thoroughly trained in the procedure.

***a demonstration** of the complete BAXTER program of blood banking and parenteral therapy can be arranged without obligation.*

Products of **BAXTER LABORATORIES OF CANADA, LTD.**, Acton, Ontario

Distributed in Canada exclusively by

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The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association, and the Blue Cross Plans.

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ELASTIC ADHESIVE BANDAGE
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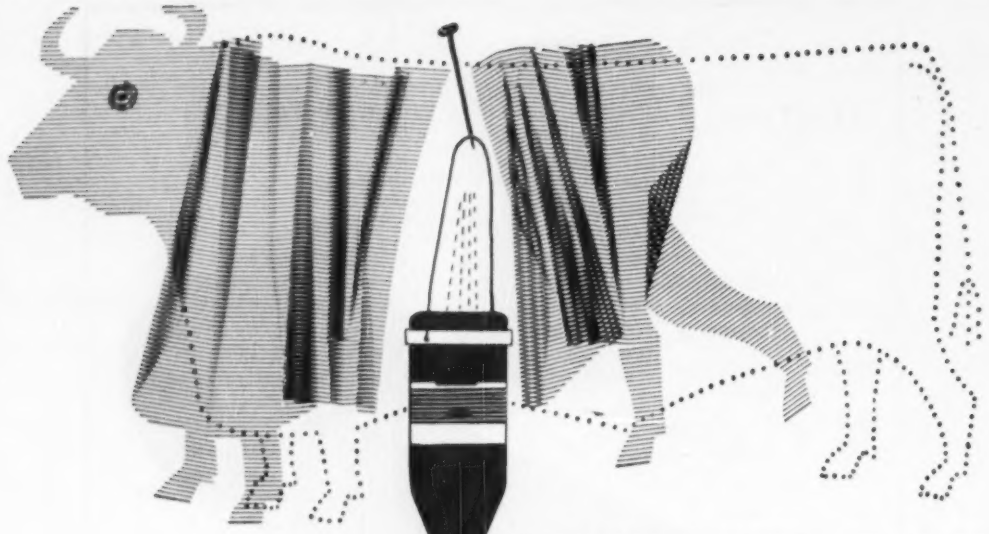
Each strip of Bandage Fabric is woven separately with individual control of thread tensions.

The improved Non Fray Edge provides the Advantage of a Bandage which will lie flat on the Limb.

By reason of the Greater Softness of Doubled Thread, the Flexoplast Fabric is more impermeable to the Adhesive spread, is cleaner on the back and softer and more flexible in use.

THE Stevens COMPANIES

TORONTO WINNIPEG CALGARY VANCOUVER



in place of meat

Whenever the nutritional needs of the patient cannot be met with oral feeding or when large volumes of plasma are not available, you cannot choose a safer, more complete source of amino acids than the AMINOSOL line of parenteral solutions.

Aminosol is derived from blood fibrin, a protein of high biologic value. With AMINOSOL as the sole source of protein, good nitrogen retention, plasma protein regeneration, weight gain and protein repletion have been amply demonstrated. AMINOSOL is sterilized both by filtration and by autoclaving and is subjected to rigid antigenicity control. Its potassium, magnesium, calcium and phosphorus content is adequate, its sodium salt content low. (AMINOSOL also available with salt added.) Vitamin B complex and vitamin C may be added to the solutions by simple injection through the rubber tubing after infusion has started.

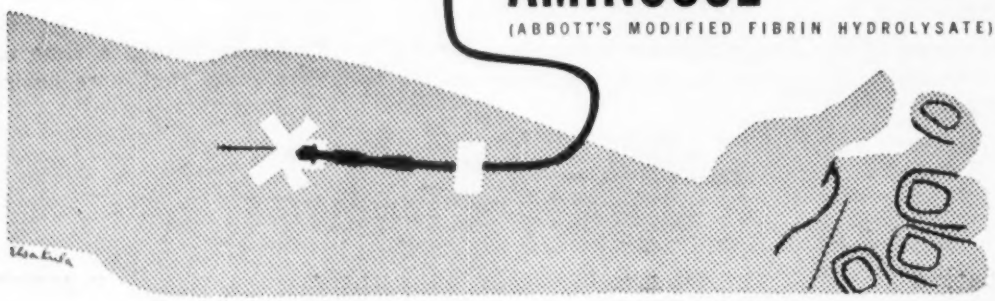
Ask your Abbott Representative how this safe, convenient, adaptable line can aid your program of protein therapy. For literature, send your card to ABBOTT LABORATORIES LIMITED, MONTREAL.

5% Solution.
5% with Dextrose 5%.
5% with Dextrose 5% and Sodium Chloride 0.3%.

AMINOSOL®

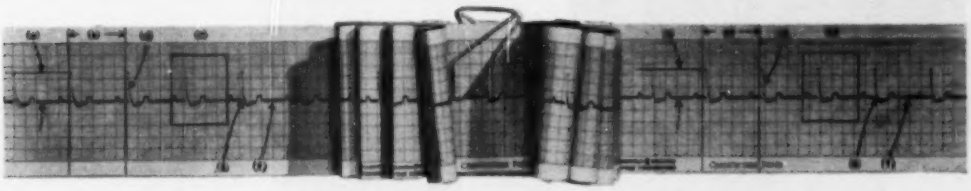
Abbott

(ABBOTT'S MODIFIED FIBRIN HYDROLYSATE)



ONE FOOT OR FIFTY

there's never a single variation in Cardioscribe Recordings



YES, actual Cardioscribe test recordings prove consistency of operation. The above recording is that of an "artificial heart" — an electrical device designed to produce an electrical potential simulating that of the human heart. This test is applied to prove the efficiency of every Cardioscribe before it is approved for shipment.

In comparing the starting and finishing ends of this 30-foot roll of continuous recording, note the unvarying consistency of operation as it pertains to (a) amplitude, (b) timing, (c) wave form, (d) rapid deflection, (e) definition — slurs and notches, and (f) absence of drift in the base line.

GENERAL ELECTRIC
X-RAY CORPORATION
LIMITED
MONTREAL TORONTO VANCOUVER WINNIPEG

LEAD SELECTION VIA PUSH-BUTTON CONTROLS

The Cardioscribe provides for a wide diagnostic range by facilitating the application of the following combinations of patient leads:

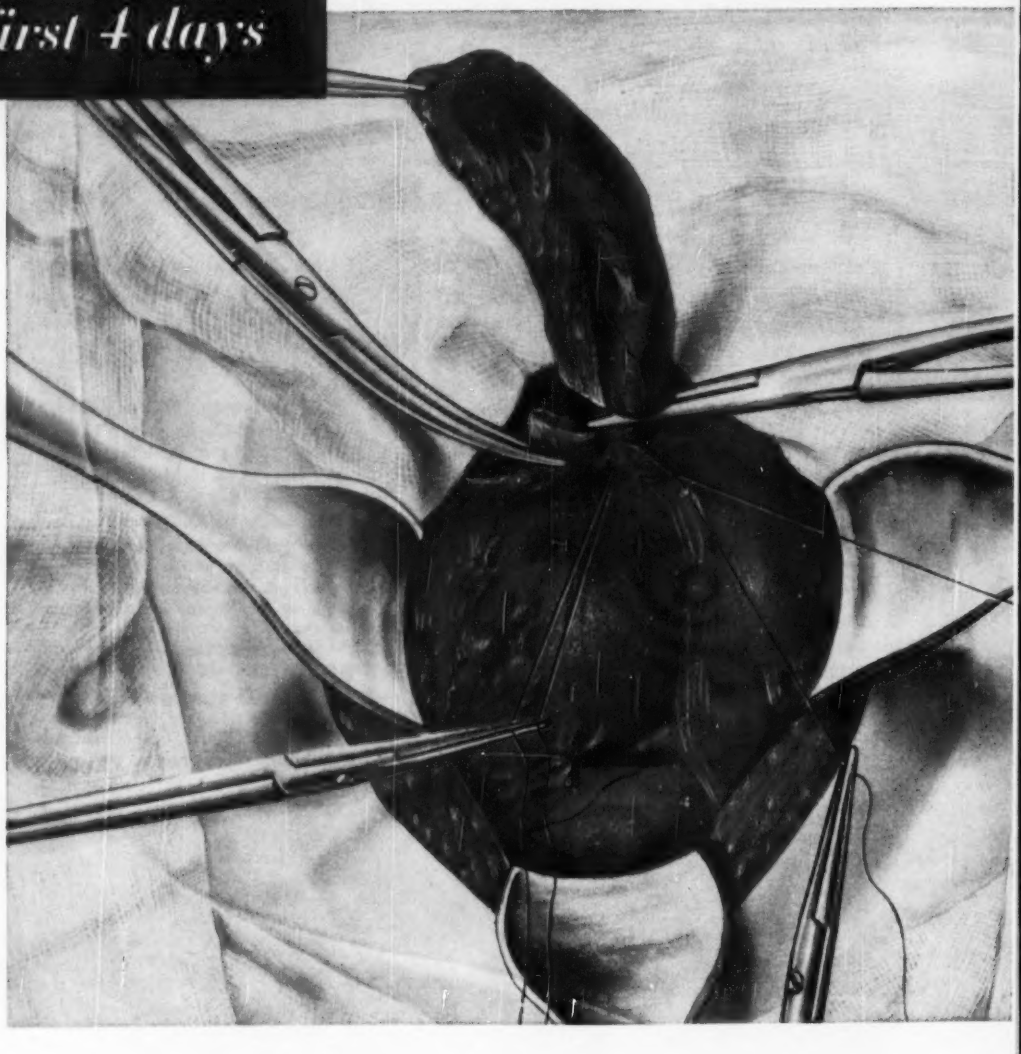
1, 2, 3 — Standard Extremity Leads
aVR, aVF, aVL—Augmented Unipolar Extremity Leads (Goldberger)
VR, VF, VL — Unipolar Extremity Leads (Wilson)
V (1 to 6 incl.) —Unipolar Chest Leads

Seven push-button controls make it possible to automatically select any of the above leads without necessitating any change in the patient's electrodes other than that of properly positioning the exploratory electrode when unipolar extremity leads or unipolar chest leads are employed.

Ask your GE representative for a demonstration, or write for free booklet — General Electric X-Ray Corporation, Limited, Montreal, Toronto, Vancouver, Winnipeg.

During the first 4 days

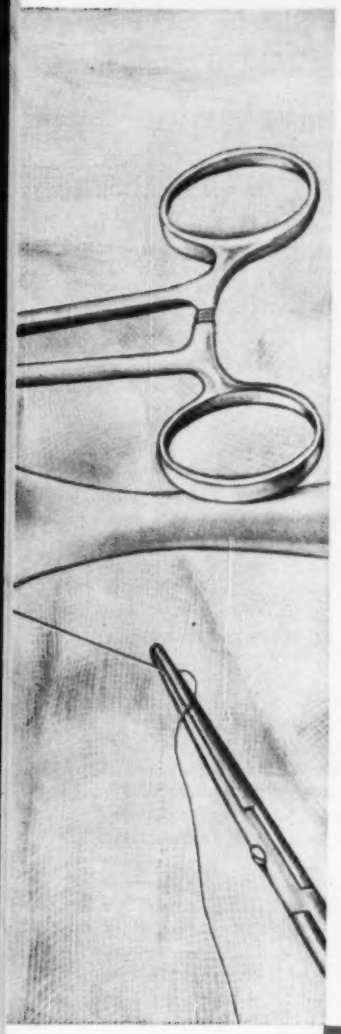
... the stump *must*



"Timed-Absorption" catgut (surgical gut) will not digest prematurely after an appendectomy or other major surgery. It provides wound support for the complete duration of anticipated healing time. Digested at a measurable and predictable rate, "timed-absorption" catgut sutures assure strength when needed most.

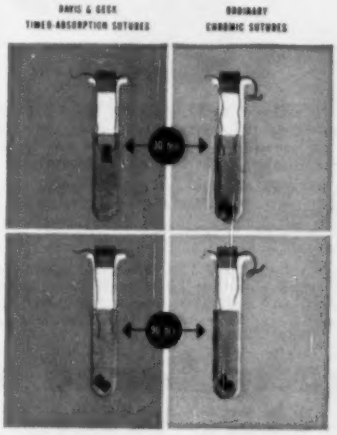
DAVIS & GECK, INC.

hold!



"TIMED-ABSORPTION" CATGUT

Processed by an exclusive improved method, only "timed-absorption" catgut (surgical gut) sutures embody accurately *graded degrees of tanning* from the outer surface inward to achieve a more logical absorption curve. Maximum resistance to digestion is assured *during early stages of wound healing* when the wound is weakest. As healing advances and the need for artificial support lessens, the absorption rate increases and the strand dissolves completely with minimal tissue reaction. No remnants of gut remain.



Comparison of D & G "timed-absorption" medium chromic catgut suture, size 0, with ordinary medium chromic size 0 catgut sutures. Both types of catgut are suspended in a trypsin solution and weighted. Note that at the end of 30 hours "timed-absorption" catgut remains intact; the weight is still held suspended up to 90 hours. Contrast with ordinary chromic catgut suture which has begun to digest and breaks under the slight tension created by the weight at 30 hours. In human tissue all chromic sutures are digested more slowly, but the ratio between the two types remains the same.

Finished with a satin-matte surface, D & G "timed-absorption" catgut sutures tie readily and do not slip at the knot in contrast with slick, highly "polished" strands. Pliability is exceptional and tensile strength, diameter for diameter, is unexcelled by any other brand.

There is a D & G suture for every surgical purpose.
Available through responsible dealers everywhere.

DAVIS & GECK
"timed-absorption"
CATGUT

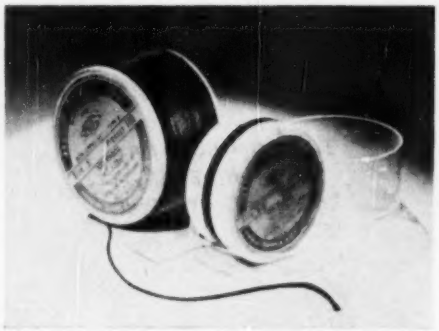
57 Willoughby St., Brooklyn 1, N.Y.

Across the Desk

By C.A.E.

D&G Announces Improved Anacap Silk

Davis & Geck, Inc., has announced the introduction of its new, improved Anacap Surgical Silk which has proved to have five outstanding qualities, namely: greater tensile strength; absolute non-capillarity;



easier handling; continued strength after repeated sterilization and economy of material.

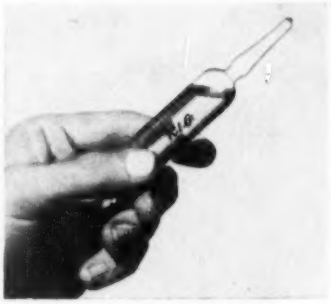
The new Anacap Silk, developed after extensive laboratory tests, is being announced to surgeons and hospitals throughout the United States and Canada in an aggressive promotional campaign which includes stepped-up field contacts, increased direct mail and journal advertising, as well as wide-spread sampling and convention activities.

* * * *

Rust Inhibiting Germicide

R.I.G., a new, permanent rust inhibiting germicide concentrate for the cold disinfection of medical instruments and appliances is announced jointly by Clay-Adams Co., Inc., New York, and Professional Specialties, Inc., St. Louis, Mo.

No rust or film will form on instruments left in R.I.G. even after six months of immersion, tests reveal. R.I.G. concentrate is colourless, odourless and stable both before and after mixing. It has a high germicidal efficiency — and wide safety margin — against many types of pathogenic bacteria. R.I.G. concentrate is packed in 10 ml. ampules



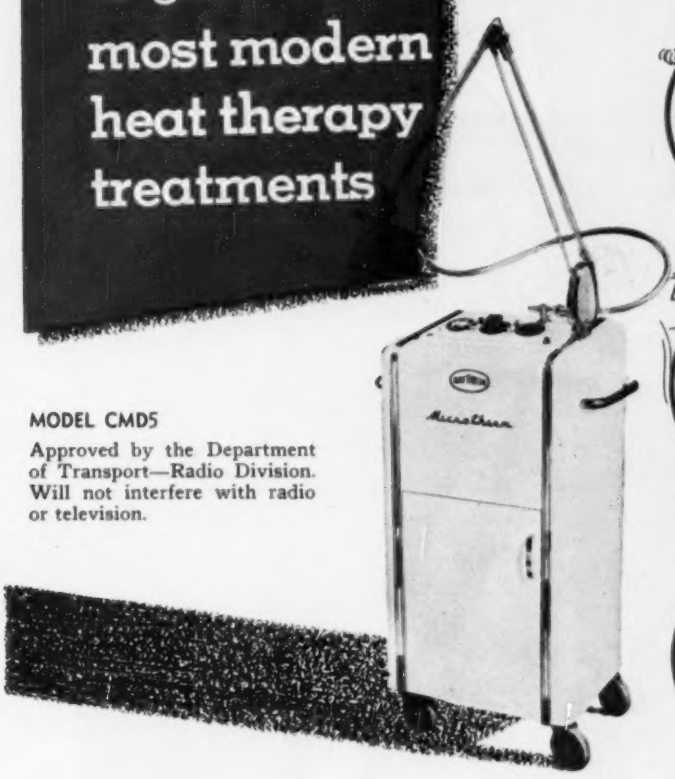
(Continued on page 16)

You need Microtherm Diathermy to give the most modern heat therapy treatments

Microtherm employs Radar MICRO-WAVES—not merely "short waves"! That means you get

- greater absorption
- desirable ratio of cutaneous to muscle temperature
- more even heat in fat and vascular tissues
- increased local blood circulation
- no contact between patient and directors

The Raytheon Microtherm is the only diathermy apparatus which generates stabilized radar frequencies—90 times shorter than conventional diathermy range.



Easy to use; simply aim the radiation; no need to "tune in" the patient.

Shockproof — no electrodes — no danger of "arcing".

Interchangeable directors for various field sizes and shapes.

MODEL CMD5

Approved by the Department of Transport—Radio Division. Will not interfere with radio or television.

With the simple method of application offered by the new Microtherm you can now treat one patient while consulting another.

X-ray AND Radium INDUSTRIES LIMITED

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At Last! THE PERFECT SWEEPING COMPOUND
PATENT PENDING
GR. WEIGHT 60 LBS.
WAXKOTE
ABSORBS GERM LADEN DUST
DIRECTIONS
DIRECTIONS
FOR EVERY TYPE OF FLOOR

Across the Desk

(Continued from page 12)

and is diluted with one liter of soft or hard water to make a highly efficient, rust inhibiting germicide. It is also available in pint cans for hospital use.

* * * *

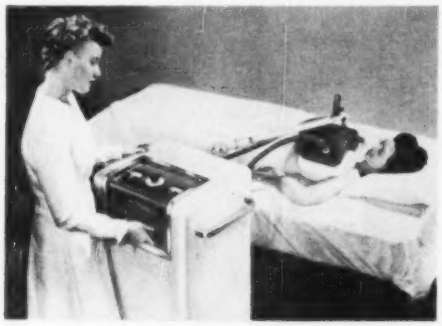
Johnson & Johnson Appointment

F. M. Falls has recently been appointed Assistant Director of the Hospital Division of Johnson & Johnson Limited. A former Squadron-Leader in the R.C.A.F., and holder of the D.F.C. and Bar, Mr. Falls began his activities with the Johnson & Johnson organization in the early summer of 1950. Prior to this he attended McGill University.

* * * * *

G. E. Inductotherm

From diathermy treatment of the ear to that of a pelvis or chest, the Model E Inductotherm, developed by General Electric X-Ray Corporation, offers a most practical and efficient means of obtaining the desired quality and intensity of energy indicated for the particular area and condition under treatment. The Inductotherm is correctly designed to fulfill your needs over the entire range of modern diathermy technics.



Furthermore, the Inductotherm now embodies all requisites stipulated by the U.S. and Canadian governments to preclude interference with radio communications.

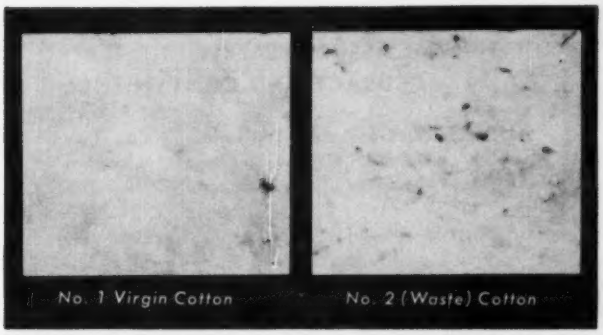
For detailed descriptive literature address any one of the G-E X-Ray offices in Canada.

(Concluded on page 20)

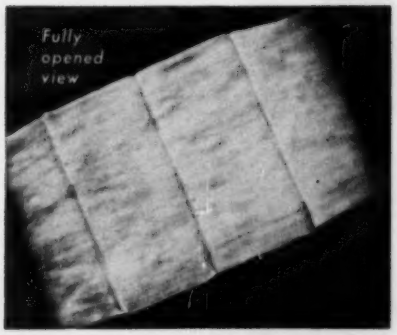
IN COTTON-FILLED SPONGES . . .

only ZOBEC* filmated

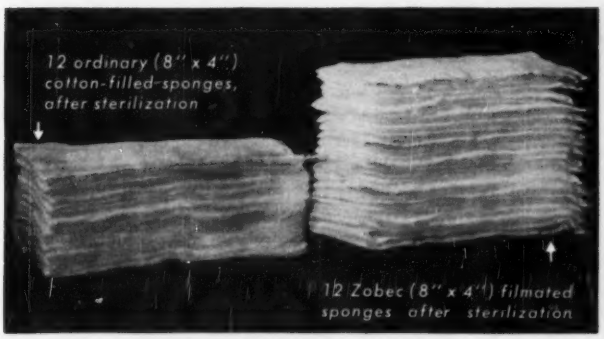
offers all these advantages!



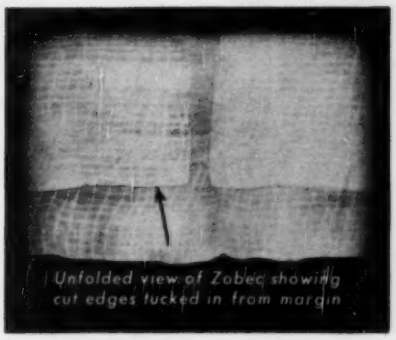
1. Zobec is the only cotton filmated sponge with No. 1 virgin cotton.



2. Even filmation covers the entire gauze area—gives even diffusion of drainage, greater aeration, and softness on all surfaces.



3. Zobec provides more dressing volume — greater fluff after sterilization.



4. All cut edges turned in—free from loose ravelling gauze threads.

Specify ZOBEC* Sponges—
obtain *all* these advantages.

Made in Canada by

Johnson & Johnson
LIMITED MONTREAL

*Trade Mark Reg'd.

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TEL-O-SEAL CONTAINERS
For I.V. solutions. Permits routine sterility check during storage period. Available in 350, 500, 1000, 1500 and 2000 ml. sizes.

In spite of the current spiral of inflationary costs, your skill plus Fenwal Equipment and Technics can effect drastic reductions in the cost of intravenous solutions for your hospital.

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For sterile water and saline technics. Available in 350, 500, 1000, 1500, 2000 and 3000 ml. sizes.

FENWAL ASSURES SAFETY, ACCURACY AND CONVENIENCE

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4 Automatic washing and filling equipment and accessory apparatus.

5 A background of 10 years of satisfactory operation in many leading hospitals throughout the world.

FENWAL offers to hospital pharmacists, by virtue of their scientific training, experience and position, the means of effecting substantial and immediate economies for affiliated hospitals . . . and in addition . . . the opportunity to enhance the prestige of their pharmacy services.

AMP-O-VAC—
The Reusable Ampule
Reduces the waste of novocaine and similar medications by permitting periodic withdrawals as required without exposing balance of contents to air. Container and hermetic closure may be repeatedly sterilized. Available in 75 ml. size only.

• Fenwal representatives are equipped to assist you in the selection, installation and operation of equipment best adapted to meet the volume requirements of your hospital.

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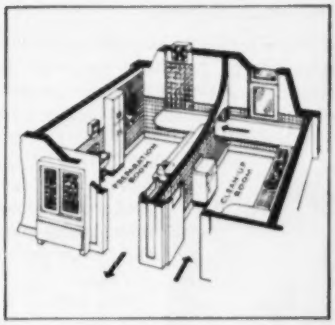
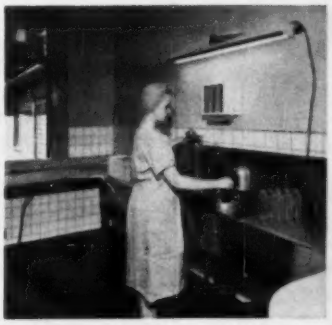
THE Stevens COMPANIES
Exclusive Canadian Distributors, Toronto, Winnipeg, Calgary, Vancouver

Safe, simple preparation of milk formula



This carefully planned work flow production line saves time and steps in formula preparation.



Washing room. Only clean technique must be observed here since bottle, nipple and cap will be subject to terminal heating as final step.

Formula room. The entire product—formula, bottle, nipple and nipple cap are placed in the autoclave for terminal heating at 230°F. for 10 minutes.

Parents, in this case, see the care that is taken to protect their infant. Note the refrigerator on left. It is filled from the Formula room and is accessible from corridor.

Rectangular autoclave for large volume. Cylindrical and rectangular autoclaves available for capacity from 32 to 384 bottles per load.

Mobile bottle warmer—for transportation of bottles to the nursery. Warms bottles to 102°F.

Bottles, nipples, and nipple caps are washed clean. The entire assembly of bottle, formula, nipple, and nipple cap . . . all in place . . . is placed in the sterilizer chamber. It is heated at 230°F. for 10 minutes.

It is as simple as that—and no amount of elaboration will improve the end result.

Hospitals throughout the country have found this simple technique completely safe and satisfactory.

For experienced help in improving your formula preparation facilities see your Castle dealer or write: Wilmot Castle Company, 1176 University Ave., Rochester 7, N. Y.

THE STEVENS COMPANIES
TORONTO WINNIPEG CALGARY VANCOUVER

Castle

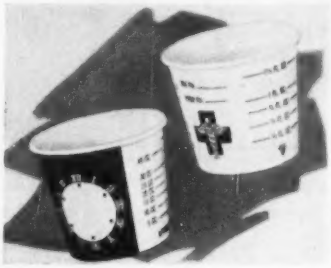
CASGRAIN & CHARBONNEAU, LTD., MONTREAL

Across the Desk

(Concluded from page 16)

New Medicine Dixies

Medicine Dixies were created to satisfy the growing demand of hospitals, doctors, sanatoria, and other institutions for an attractive, graduated, single-use medicine cup. They are used for prescribing pills and other medicines, rinsing the mouth, gargling, and for general sickroom use. Since they are used but once and then thrown away, their economy is obvious.



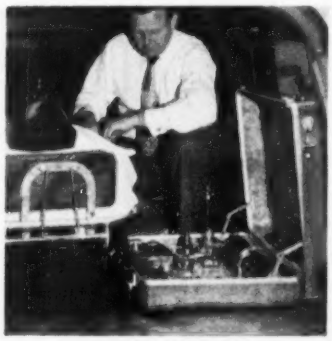
The side of the cup bears gradations showing ounces, teaspoons, tablespoons, and cubic centimeters, and the time for taking the dose can be conveniently marked on the clock-face portion of the design with a 4B or other soft lead pencil. It is practical for rinsing the mouth and gargling because the single-use cup is thrown away immediately after use and cannot act as a carrier of colds, sore throats and other contagions.

Samples and prices may be obtained by writing Dixie Cup Company (Canada) Limited, Brampton, Ontario.

* * * *

Life-Saving Apparatus

New life-saving apparatus introduced at the National Safety Congress in Chicago in October by the Mine Safety Appliances Company is designed to treat victims of drowning, electric shock, poisonous or suffocating gases, heart attacks, overdoses of drugs or any other type of asphyxiation. One portion of the instrument provides automatic artificial respiration without suction by means of an intermittent positive pressure valve.



The apparatus, called a "Pneolator", also serves as an inhalator for persons whose breathing has resumed. The changeover from artificial respiration to demand inhalation is automatic. The company states that, because of its versatility and suctionless operation, the instrument can be used safely for any case of arrested breathing whether the cause is accidental or medical.

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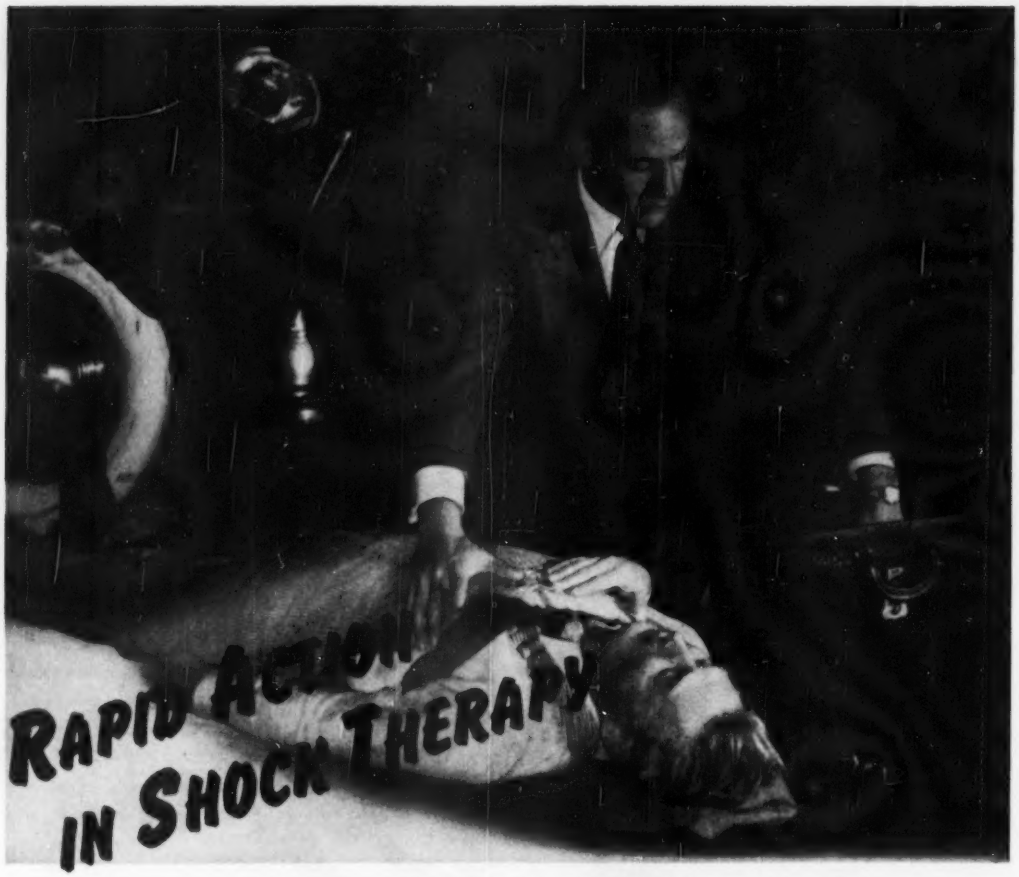

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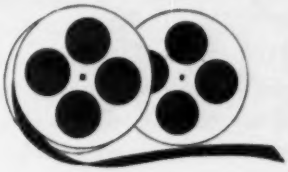

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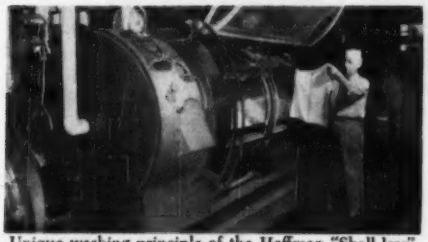

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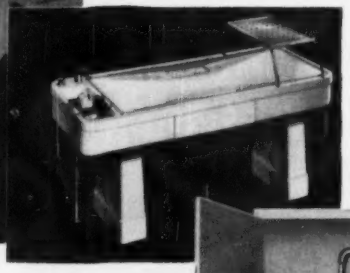
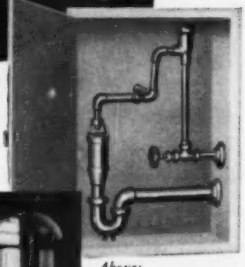
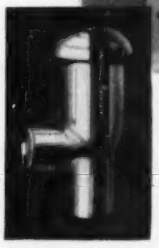


Above: the new Crane Duraclay vitreous glazed autopsy table, model C7021.





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Leonard O. Bradley, M.D., Editor

CANADIAN HOSPITAL

Toronto, November, 1950 Vol. 27 No. 11

Obiter Dicta

Too Many Hospital Beds? —Inadequate Community Services

DO WE NEED the volume of in-patient hospital care that is now being demanded and that hospital authorities everywhere are striving to meet?

Dr. Hossack's editorial in the August-September *Manitoba Medical Review** points up an issue that should be very widely and carefully examined by the hospital field, by the medical profession, and particularly by the community as a whole. From his observation during the Red River flood, he writes that "patients can be cared for successfully at home even today when technical investigation is regarded as essential for proper treatment, and it further follows that, in normal times, many patients do not need hospital beds".

A quarter of a million people in a metropolitan city had very limited and restricted in-patient hospital services on the spot and "got along quite well without the benefit of hospital facilities". In correspondence with this office Dr. Hossack says, "Before the flood every hospital was crowded and all had long waiting lists. For three weeks many hundreds of beds were empty and no one seemed to suffer. Being on the spot it amazed me to find such a small demand for hospital service—to see large institutions completely empty when a few days previously you could not get a bed for love or money."

Through well organized evacuation to the community itself, to other areas in Manitoba, and to the near-by Provinces of Ontario, Saskatchewan and Alberta, long-term patients, aged and infirm, and those more seriously ill, were afforded a continuing care of high quality. This was a fine piece of work and should be highly praised. But the lesson to be learned lies in the numbers that were discharged to home care in Winnipeg and in the amazingly low rate of admissions to hospitals from the community during the flood period.

Four parties are involved in each admission, the hospital, the doctor, the patient, and his relatives, friends, or guardians. A discussion of the responsibilities of each party would fill several volumes and will provide meat for many editorials to follow. Hospitals are not blameless, for a high level of occupancy does solve many administrative and financial difficulties. The wish of the medical practitioner is perhaps the most important single factor in tilting the balance when there is any question as to the advisability of admission. But more of this in future issues.

One of the primary lessons which should be learned, or perhaps re-learned, by all four parties, is the feasibility of good medical care *without being admitted to a hospital bed* and right at *home*. The advantages of hospitalization have been over-stated, over-emphasized, and over-practised, by all four parties.

One of the forces that is snowballing the use of in-patient hospital facilities is the high cost of diagnostic services. It is well known that both patient and doctor are taking advantage of pre-paid hospitalization schemes for "tests", for admissions for diagnosis only. Many of these are lightly cloaked with fearsome diagnosis to secure admission. Certainly, there are many advantages to the patient, the doctor, and to the hospital, too, in centralizing the diagnostic facilities of the community in the hospital. It cannot be argued that a more economical and efficient service is possible elsewhere. Today, however, it is doubtful economy, for complete in-patient admission is required to justify payment for a few diagnostic procedures. To meet this rising demand for in-patient services, we are engaged in a major expansion of hospital facilities, an expendi-

**Reprinted on page 92 of this issue.*

ture that is becoming very burdensome in capital cost today and will be an increasing burden in operating costs tomorrow.

It might be possible to come to a solution if the cost of diagnostic services were drastically reduced to a level still high enough to remain a deterrent against wide-spread abuse and yet low enough to remove the incentive for hospital admission. Admission to hospital is not without inconvenience so the doctor and the patient both might avoid it more often if diagnostic costs outside of the hospital were not too high. Implicit in this thought is the need for encouraging the building of out-patient and ambulatory facilities in the hospital and doctors' offices in the hospital. Our present Federal grant system gives a nod to this but does nothing practical about it.

The second point is the shortage of home care organization and facilities out in the community. If both were readily available, the patient and the physician might use such services much more extensively. Nursing care could be provided by visiting nurse organizations or, on an hourly basis, by the private nursing group. Home-maker services or voluntary neighbourhood groups could be organized to assist in housekeeping duties. The hospital could make arrangements to rent or lend sick-room equipment and supplies.

While we would like to see the hospital group lead in the development of these two services, responsibility rests also with the medical profession and with other agencies interested in the health and welfare of the patient.

In his final sentence, Dr. Hossack says, "we can help ourselves, the hospitals, and the really sick by keeping at home those who need go no further to get well". He has opened a small hole in the dike which paradoxically may be a great boon. Let all four groups mentioned above consider this statement without delay so that some constructive approach can be organized before hospital costs become overwhelming.

To Train or not to Train?

THOSE who have attended hospital meetings with any regularity, particularly during recent years, cannot fail to have been impressed by the persistent cry for trained hospital personnel. Programs for training nurses, nursing assistants, technicians, medical record librarians, and hospital administrators, have obviously been in demand.

The need for expanded facilities for training in hospital administration has been expressed by hospital boards, governmental representatives and, with equal emphasis, by those presently engaged in some branch of administrative work who seek to extend their knowledge and better equip themselves to discharge their tasks. One can only conclude that a sound program in hospital administration would be seized upon with the eagerness of the proverbial drowning man grasping for a straw.

Now we shall see. Such a program can become a reality—if it is wanted. How great really is the need? Does the type of project now proposed meet with favour? How extensive is the demand? Who would enrol?

Your opinion is sought. The way to express it is described in the item appearing on page 39 of this issue.—*M.W.R.*

Problem of the Aged

HOSPITALS have been more inclined than most other community enterprises to employ, and continue in employment, people who because of age are unable to secure or hold a job elsewhere. While this has not always been to the advantage of the hospital, we cannot deny that many who were considered "ancients" have made a very worthwhile contribution, particularly during the lean years of the last war.

In almost every organization, profit and non-profit, in almost every country, there has been a strong tendency, and sometimes a fixed ruling, to retire men at 65 and women (who live longer) at 60 years of age. It is most interesting to see the pendulum begin to steady and perhaps to swing back. In England, it was noticeable during the last war when the oldsters (in calendar years) were pressed back into almost every occupation in the community. They were sorely needed and came through with flying colours. Recently in Washington some 500 experts from many walks of life met to discuss the current problem of "aging". Several students of the question stated emphatically that the fixed retirement age was a penalty for many still active and productive citizens and in some instances actually a danger to their well-being. At the University of Toronto this winter, a series of 10 lectures will be given on all aspects of the problem. The time is ripe for a wide and realistic examination of the whole subject.

There are many subtleties and intangibilities that must be recognized and taken into consideration by management and that must be understood by all concerned in the hospital or any other organization. What will be the attitude of keen youngsters if promotion is slowed down by the unlimited tenure of top positions? Will the older person be able to accept with dignity a reverse promotion down the chain as he becomes less able to carry the whole job? Will the older and senior person take more time to train, educate, and develop better human relationships with his junior staff, knowing that some day these persons may be his seniors? Will the younger members of the staff be more considerate of, and helpful to, the employee who has performed long and faithful service and who is being "promoted" to a lower level?

With education taking years off one end of a productive life and compulsory retirement limiting the other end, and with the accelerated swing to shorter work weeks and workdays, it would seem that we are about to develop a shortage of productive manpower. This will affect the hospital since it is not the strongest competitor for manpower and will feel the pinch early. It may mean

that our economy will have to turn to the aged for rescue, an act which in turn may prove to be a rescue of the aged from unfilled and unhappy hours. Let's start thinking about this now.

It's the Season— and We Don't Mean Ducks

LAST month a widespread rash of hospital conventions broke out across central and western Canada reaching almost epidemic proportions. Visiting speakers and representatives of various governmental agencies, both provincial and dominion, which are interested in the health field, were almost treading on one another as they clambered aboard planes or fast trains to speed across country with a pocketful of greetings and learned treatises to disperse at various functions. Delegates from hospitals large and small, far and near, broke away from day-to-day routine to attend their provincial meetings and enjoy that opportunity to look and listen—or to air their pet peeves either in public or in some handy alcove. Either way the exchange of ideas is very salutary.

In this issue appear brief outlines of many of the meetings, though several took place so far past our deadline that it has been impossible to include them all. However in succeeding issues we plan to publish, in the form of articles, a wide selection of the excellent papers presented at the various meetings. By the time you read this, the convention fever will be almost over for this year but for hospital people life is never dull, and moreover—according to current rumours — you have only 40 more shopping days till Christmas!—*J. F.*

The Practical Value of the NURSING TEAM

Hilda M. Bartsch, Reg.N.,
Superintendent,
The Charlotte County Hospital,
St. Stephen, N.B.

IN THIS DAY of nursing shortages, most of us are interested in any plan which might enable us to make better use of graduate nurses or to spread their services to a large number of patients. The purpose of the nursing team is to give good nursing service and to provide the graduate professional nurse with an opportunity to do the duties which she can best perform.

As all hospitals would like to give the best nursing service possible, perhaps we should take a moment to define the term. It certainly does not mean hotel service, although some patients seem to feel that they should have all the luxury of a first class hotel while in hospital. If this is to be provided, people should be charged prices equivalent to hotel rates plus a charge for nursing service. Nurses provide the type of service which revolves around the physical and mental needs of the patient and helps him to re-establish himself in a normal, healthy, and well-adjusted life.

A nursing team may consist of a graduate professional nurse, a practical nurse or trained attendant, a ward aide, and a part-time maid. In addition to this group, which is directly concerned with the nursing service to the patients, are the superintendent of nurses, her assistant, a supervisor, and the head nurse—all in the background. There seems to be a considerable difference of opinion as to the number of auxiliary staff required in proportion to graduate nurses. This is a problem which has to be worked out in individual hospitals. The setting up of nursing teams would necessitate considerable staff education and an in-service program for the auxiliary staff. If the fullest use is to be made of each member of the team, the nurse in charge of the floor or the head nurse would have to allocate patients in a certain way. Thus the group of patients being cared for by a nursing team would consist of both acutely ill and chronic or convalescent cases.

Hilda M. Bartsch.

Duties

The responsibilities of each member of the team need to be clearly defined and understood. As the graduate nurse is the key member of the group, let us consider the qualifications which are necessary for her position. She should:

1. Know the duties and responsibilities of each member of her team;
2. Have an over-all picture of the nurs-

An address presented at the Maritime Hospital Association Meeting, St. Andrews-by-the-Sea, N.B., June, 1950.

ing care to be provided for each patient;

3. Have a knowledge of the basic principles of teaching, supervision, and administration;
4. Be able to give encouragement and constructive criticism to auxiliary workers;
5. Have the ability to make the members of the team feel that they are necessary for the welfare of the patients;
6. Make each individual member aware of her duties for a given period;
7. Allow all members of the team to make suggestions.

The graduate nurse is also responsible for seeing that all doctors' orders are carried out, and for giving all medications, complicated treatments, and bedside care, to acutely ill patients.

The practical nurse or attendant should have training in a well organized school which gives a course of at least nine months. Her period of field training should be supervised by a graduate nurse and if a system of licensure could be introduced, she would have both legal recognition and protection. In the nursing team, such a person could give nursing care to convalescent and chronic patients, give minor treatments, help with meal service, and assist the graduate nurse when and where needed. The aide, an individual with in-service training only, cares for flowers, runs errands, obtains supplies, serves drinks and fluids under supervision, and performs many of the non-nursing duties on the ward. The maid, if not on the housekeeping staff, is responsible for the ordinary housekeeping duties in the space occupied by the patients assigned to the nursing team.

To organize and carry out group nursing, the services of a supervisor are required. She should be a nurse with maturity, broad experience, and the necessary educational qualifications. She must plan and carry out an orientation program for each member of the team, as well as organize and implement the teaching schedule for nurses' aides. Her supervision of the nursing team should be in the form of inspection. She should look for facts not faults and should offer guidance and encouragement.

The Student on the Nursing Team

In hospitals with schools of nursing, practical nurses or trained attendants are not usually employed. However, if there were a system of licensure for practical nurses from recognized schools, there is no reason why they could not be used to good advantage. Although student nurses are assigned to cases which can provide them with good clinical experience, practical nurses in the nursing team could look after other patients. The student would be freer to carry out good nursing care and this, in turn, should contribute to a better over-all nursing service. While it might seem unwise to place the student nurse on the team during her first two years, in her third year she could begin to assume this leadership and responsibility with the assistance of the supervisor and the head nurse.

All members of the nursing team must be emotionally stable individuals, with good judgment and common sense. In particular, the auxiliary members of the team must be the type of people who are safe to have around patients. If hospitals are going to employ and retain desirable people for nursing teams, good personnel policies are needed. Otherwise, they will fail to attract the best type of employees for such a program, or, if they do obtain them, a high turnover rate will result. Thus it would not only be difficult to carry out a scheme of nursing teams but the cost of nursing service would be increased as well.

CONVENTIONS

See pages 40 to 60 of this issue for reviews of provincial association meetings which took place last month.

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* * * *

Un Résumé

Il existe actuellement une pénurie de gardes-malades diplômées. Il s'agit d'organiser une équipe de "nursing" dans laquelle les services de la garde-malade diplômée sont employés avec le plus de profit. Cette équipe devrait être composée d'une garde-malade diplômée, d'une aide entraînée (practical nurse) d'une aide pour les salles et d'une servante. Il est difficile de préciser la proportion des diplômées avec le personnel auxilliaire. Tout dépend de l'hôpital en question.

La garde-malade diplômée assume plusieurs responsabilités. Elle doit posséder une formation adéquate et les qualités nécessaires pour diriger le reste du personnel. L'aide entraînée doit avoir subi un entraînement sérieux de neuf mois dans un endroit dirigé par des diplômées. L'auteur suggère que ces aides devraient recevoir un diplôme à la fin de leur entraînement. L'aide garde-malade fait toute les petites besognes de l'étage. La servante fait le ménage.

Les services d'une surveillante sont nécessaires pour organiser une équipe de "nursing". Cette garde-malade fait l'inspection du travail; elle doit rechercher non seulement les fautes mais aussi les faits accomplis. Dans les hôpitaux possédant une école de gardes-malades l'emploi d'aides entraînées n'est pas requis. Cependant leurs services pourraient être mis à profit pour venir en aide aux étudiantes gardes-malades. Ces étudiantes surtout dans leur troisième année peuvent prendre leur place sur l'équipe.

Les membres de l'équipe doivent être des personnes équilibrées. C'est en gardant un niveau élevé que les hôpitaux obtiendront un personnel de choix.—*Yves Prévost, M.D.*

Are You an Ambassador of Good Will?

Allan Craig, M.D.,
New York, N.Y.

THE chief activity of a hospital is, and always must be, the medical care of its patients. While we must always live within the bounds of medical ethics, we must also realize, if we are awake to our responsibilities, that we are striving for the good will of the public for the care of whose health we are in a large measure responsible.

The tempo of history has quickened. Twenty years ago information concerning medicine and hospitals was somewhat subdued but, today, we in the hospital field are serving an intelligent and inquiring public who are interested in what goes on in our institutions. The advertising slogan of one of our large automobile manufacturers, "Ask the man who owns one", might well be paraphrased for our hospitls, "Ask the patient who has been there". More and more the question as to their experiences in hospitals is being put to former patients, their families, and their friends. It therefore behooves the administrator of every hospital to look well to the internal establishment of good will as well as to outside educational publicity.

Let no hospital administrator underestimate the value of a well-established and productive policy of community relations for his hospital. Favourable public opinion, it may not always be realized, is the sum of individual good will on the part of its patients and their friends and is one of the most precious possessions of any hospital. In the long run it is one from which rich dividends may be anticipated and in many cases have resulted.

An Ambassador

The hospital administrator is the personal representative or ambassador of his or her hospital in the community and throughout the area from which the institution draws its patients. If the head of the hospital expects others to take an interest in his hospital, he must also take a reasonable interest in community affairs and, in so far as possible, participate in community activities.

No hospital administrator, who surrounds himself with a shell of isolation, can be fully effective in carrying out these obligations to his institution.

Good will toward a hospital cannot be achieved entirely through publicity nor can it be purchased with dollars and cents. Educational publicity of an ethical and understandable type is, of course, necessary and of great value to the hospital. If, however, we describe and advocate good hospital care and educate the public to appreciate the important place of the hospital in the community, we must "practise what we preach" in our day-by-day living and look well to our activities within the hospital itself.

The establishment of an efficient public relations department in a hospital is commendable but it does not relieve the administrator and his associates of individual responsibilities for daily contacts—which can mean so very much in the building up of a reputation for human kindliness as well as efficiency.

Every administrator should in so far as possible know the patients in his hospital. One of course must realize that in large hospitals this may not be possible from the standpoint of personal contact with all patients; but a daily review of admissions and discharges is well worth while and a certain number of patients can be seen each day.

The hospital administrator who fails to make patients rounds, daily if possible, is missing one of the greatest opportunities for the establishment of good will on behalf of his institution. Patients like to see the man at the top and to feel that he takes a personal interest in their welfare.

Visitors

Furthermore, one might well ask every administrator this important question: "How are the families of patients treated at visiting hours?" Very much indeed could be said on this subject alone. The problem is one that, generally speaking, must be worked out for each hospital and merits careful study by the administrator. Many visitors are confused when they enter a hospital and an information clerk cannot leave her desk to guide them. Here is an excellent job for two or more receptionists who can as a rule be recruited from the ranks of volunteers. Such services can in many cases be supplied by the women's auxiliary of the hospital. Also, the problem of inquiries from family

(Concluded on page 98)

From an address presented at the A.C.S. Sectional Meeting held in Montreal, March, 1950. Dr. Craig is a member of the firm, Neergaard, Agnew, and Craig, New York and Toronto.

Fission Chips

How can we prepare for an atomic attack?

G. W. Peacock, M.D.,
Assistant Superintendent,
Kingston General Hospital,
Kingston, Ontario.

MANY of us when we first heard of the atom bomb listened with relief and satisfaction. It was on our side and was being used against our enemy. Furthermore, we felt that, although it was a terrifying thing, it would hasten the end of the worst conflict in history and, as such, was probably a justifiable weapon.

Now, after several years of reflection, it is clear (with the realization that Russia also has the bomb) that we are living in a new world of thermo nuclear weapons; weapons of such a vast and unrealized power that they are capable of producing casualties on an unprecedented scale. Civilian casualties, as in World War II, could exceed the military. War today shows little regard for the civilian. It is obvious that in an all-out war advantage would be taken of the fact that an army would find it impossible to fight with the home front disrupted. Production areas and their environs will be prime targets in order to deprive the fighting men of their supplies. The old days are gone when the army could fight alone and live off the country. War today is everybody's business. We are all in the front line, especially the civilian.

What is the Atom Bomb?

Essentially the atom bomb works by bringing together about 30 pounds of U-235 or less than 10 pounds of plutonium—the critical amount necessary to sustain a chain reaction. Once the required number of pounds of material are assembled the reaction begins immediately, started by spontaneous atomic changes or fission which continually occur in the metal.

The power of the bomb comes from the process of fission in which an atomic nucleus is split, thus permitting the release of some of its binding forces. Fission can be adequately produced only in the heaviest elements the atoms of which break into smaller fragments. (Plutonium and U-235 are the only suitable ones for use in the atomic bomb). When these types of fragments are present and are struck by stray high speed neutrons (as each atom splits) a minute amount of the original mass is converted into an enormous burst of energy. At the same time, the fission fragments throw out two or three neutrons and each of these may go on to split another atom. This is a chain reaction—one fission causes two, two produce four, four give rise to eight, et cetera. This action is so fast that all the energy is released almost instantaneously.

What is the Hydrogen Bomb?

The power of the hydrogen bomb would be fifty times that of the atom bomb and might destroy ten times the area. Thus, where the atom bomb would destroy approximately two square miles, the hydrogen bomb under the same circumstances would probably affect ten square miles. Whereas the atom bomb is a fission type of reaction, the hydrogen bomb is a fusion type —as exemplified by the sun which receives all its energy as the result of the fusion of hydrogen atoms in its interior.

One cannot say whether we have the bomb or not. However, Einstein recently said that it was an attainable goal and, if achieved, then the radioactive poisoning of the atmosphere, together with the total annihilation of all life on earth, have been brought within the range of technical possibility. With its explosion there would be the liberation of tremendous numbers of neutrons which can enter any substance in nature and so render it radioactive.

Expected Results of an A. Bomb Blast

For planning purposes many casualties must be anticipated among people within 3,000 yards and openly exposed to an air burst bomb. While ordinary buildings would provide some protection against flash burns, they would be of little use against ionizing radiations. Further, they might increase the chances of indirect blast and fire casualties due to falling and burning structures. As a conservative estimate, one might assume that all persons within this 3,000-yard range would be casualties of whom one-third would die immediately; one-third soon after; while the remainder would be seriously injured requiring extensive and specialized medical care for survival. Looking at it in another way and based on the experience of Japan, it is probable that in a large city in Canada there would be 50,000 deaths and about 60,000 casualties from the explosion resulting from a well-placed bomb.

Injuries and deaths may result from a variety of different hazards in the event of an atom bomb attack. At the moment of explosion immeasurable heat and radiations of vast energy are produced and give very serious burns. Casualties from this particular type of injury will be numerous and those surviving will need not only emergency care but also provision for long convalescence.

As a result of the blast a terrifically powerful series of air waves are induced and these will cause structural changes and death to those exposed. This air blast is particularly prone to affect the body at the interphases between air and tissue as in the lungs and intestines.

Furthermore, all medicine, food, clothing, water supplies, et cetera, will have to be suspected of radioactive contamination because of exposure to falling dust, especially

Camera Records Hospital's Development

This aerial view of the Cornwall General Hospital, Cornwall, Ontario, shows the latest extension developments. A new wing, pictured at the rear of the photograph, was opened in June, 1949, as a further step to modernize and extend the hospital's facilities. The new building, consisting of three storeys and a basement, is built of reinforced concrete and brick and was constructed at a cost of about $500,000 exclusive of furnishings which were donated. This new addition has doubled the bed capacity, bringing it to approximately 150.

A completely modern kitchen, which serves the entire hospital, is located in the basement of the new wing. Space has been provided for private, semi-private, and public wards on all three main floors. On the first floor are the laboratory, x-ray departments, and a paediatric unit, on the second the operating rooms, and on the third the maternity section.

down wind. In addition, there will be the further hazard of contamination by "fall out" from the atomic cloud as happened at Nagasaki. In the New Mexico experiments this "fall out" occurred at a distance of fifty miles from the site of the explosion, this being the distance the cloud travelled before the deposition of the fission products.

What Can We Do?

It is necessary to give some serious consideration to our position in the event of an atom bomb attack. Now is the time to think these things out and arrange our plans for disaster control. There will be little opportunity for preparation if our first warning consists of a blinding flash; one that is associated with a temperature of 1,000,000 degrees Fahrenheit, the emission of deadly radiation, and an air pressure one thousand times greater than normal. In this case everyone within a half mile radius will probably be dead or dying and all primary damage done in a ten-second period of time.

We hope that this control will not be needed. However, as many people feel that war is inevitable, because of our geographical position Canada could be another Belgium—or the ham in the sandwich between the U.S. and the U.S.S.R.

If we are bombed the casualties inevitably will be heavy—in a matter of seconds and without previous warning. All will need emergency aid and, in most cases, a long period of convalescence and specialized medical care. To cope with this an organization will have to function efficiently under most difficult circumstances. In many cases the hospital, even though not destroyed, in all probability will be unavailable to the injured. This inaccessibility may result from a variety of causes. Many of the customary services will be disrupted, and much of the area and supplies will be rendered useless, either because of destruction or radioactive contamination. We must be so organized that our defensive preparations are decentralized and each unit is ready to give or receive help from contiguous points. Mutual help and co-operation which knows no boundary will be one of our chief aids. This type of organization will need to be federally initiated and supervised, with the country being divided into various areas which have been organized previously. It must also be able to provide a prompt and effective method of helping to meet this type of crisis.

(Concluded on page 100)

Food and Its Service

Sponsored by the Canadian Dietetic Association

A sparkling Christmas tree, with a jolly Santa on the wall, can give a dining-room that special festive air.

'Twas the Month Before Christmas

The Dietitians,*
Deer Lodge Hospital,
Winnipeg, Man.

WITH the advent of brisk fall days, the thoughts and energies of dietitians are directed toward the Christmas season. They ponder and wonder what can be done to make the trays and dining-rooms more attractive than last year. Throughout all lands there is no one day in the year more important than Christmas. This is particularly true in a hospital where everything should be done to make it as gay and happy as possible for those who are not able to be with their families.

Some of the ideas outlined here may be familiar to you, as really, "there is nothing new under the sun". Our decorations are derived from the usual Christmas motifs, with construction kept as simple as possible. This point must be kept in mind, especially in hospitals where several hundred items may be required and the work is done after hours with the help of friends of the dietetic department. It is also necessary to remember that not all dietitians are artistically inclined or nimble-fingered!

The cost factor is one which none of us is allowed to forget. So rest assured that there is no great expense in making any of the following favours and, in many cases, material at hand can be utilized.

Menus and Place Cards

The bell-shaped menu (see illustrations of menus) is cut out of heavy red paper. The menu is typed in red on white paper which is cut the same shape only slightly smaller. This is inserted between two red bell shapes, stapled at the top, and a holly sticker is used to conceal the staple. The bell outline and greeting are done with white ink.

The holly-shaped menu is cut out of heavy green paper. The outline, greeting, and menu, are printed in white ink. This menu could also be made similar to the bell-shaped one, that is, in the form of a folder, and perhaps this way it would be more effective.

The Christmas tree menu, an old favourite, is cut out of heavy green paper. Two shapes are stapled together in three or four places down the centre with a fold made here to make the tree stand up. The menu is printed on one tree, the greeting on the other.

A poinsetta and candle design can be used as a place card, or if made larger, can serve as a menu with the printing on the poinsettia base. This base is cut out of heavy red paper. The candle is a roll of heavy green paper. The bottom of the candle should be cut in four places, half an inch up, and this portion is inserted in a hole cut in

Ah, to be in a hospital, now that Christmas is here!

**The authors do not wish to be named, since this article contains the ideas of many members of their staff, both past and present. They also state that they will be glad to give more detailed directions, about any item described, upon request.*

the centre of the base and then is pasted back onto the bottom of the base. The flame is a tuft of cotton wool.

Very effective menu folders or place cards may be made by pasting cut-outs from old Christmas cards onto folders or cards of heavy green or red paper. The patient's name and greeting can be printed in white, silver, or gold ink.

Christmas Favours

The major part of the work involved in making favours can be done well in advance, lessening to some extent the usual last minute rush.

Very attractive pine cone Christmas trees can be made. First of all, the edges of the cone are daubed with white poster paint and sprinkled with coloured beads or sugar while the paint is still wet. The sugar can easily be tinted with red or green food colouring. Pop bottle tops covered with silver paper can be used as the stands, with a little cotton wool at the base to resemble snow. The stand can then be glued onto a place card of green or red paper. Larger cones can be made in the same way for table decorations.

The snowman (see picture) is cut out of heavy white paper and a layer of sheet batting is cut the same shape and pasted on the paper. Lining of envelopes or parts of old Christmas cards, whether red, green, silver, or gold, can be used for the hats. The eyes and buttons can be easily applied by using an eye dropper and diluted black poster paint. The shovel or broom is a sucker, wrapped in red tissue paper and attached to the figure with scotch tape. A four-ounce paper cup is fastened to the back of the snowman and filled with candies and nuts the day before Christmas.

The chimney candy box is very simple in construction. It is made of heavy red paper cut 8½" by 4" with bricks (¾" by ⅞" long) lined across in white ink. There are 4 folds, 2" apart with a ½" lap under the first side which is stapled or glued. A cut is made 1¼" up from the bottom on each fold and these pieces are folded to form the bottom of the box which is 2" by 2½" deep. Poster paint can be brushed down from the top to resemble snow and a Santa Claus sticker attached to the inner side at the back. The boxes can be filled later with nuts and candies.

The Christmas box (see picture) is another simple but effective form of candy box. It is made of heavy white paper, cut 10½" long by 3¼" deep. Four folds, 2½" apart, are then made with ½" lap glued under the first side. Each side is folded down ½" and a 2½" square pasted over to form the top. The bottom is open so that the box can be dropped over a paper cup of candies. Fancy scotch tape is fastened on to resemble ribbon with a small piece of balsam or holly attached to the top, all of which can be done a day or so before Christmas.

'Twas the Night Before . . .

'Twas the night before Christmas
and all through the ward
Not a creature was stirring,
not even switchboard.
Fruit, candies and menus
fill all of the place
In the dietitians' office
and neighbouring space.

The dietitians were stretched
on their beds simply poohed,
Decorations were finished,
let's hope they stay glued!
Their dreams are a series
of kaleidoscope view:
"This lot makes two hundred —
What! one more to do?"

A battalion of snowmen march
right through their dreams,
Each one made of white cotton
and glued at the seams;
Their expressions are varied,
some leer, and some grin —
It depends on who drew
the faces on him.

Lines of Christmas tree menus
so densely inhabit
A great section of table —
a gay forest elaborate.
Stockings are laid in a row
with great care,
Stuffed full of candy
to finish the fare.

Stenos and staff have all
helped with the flurry
Of intricate "Art" and
last minute scurry.
After everything's finished
it's always the rumour:
"Next year," we all moan,
"we'll start even sooner!"

No one begrudges the time
spent in making
Pictures of Santa plus
trimmings for baking,
The pleasure of patients,
in fancied-up trays,
Is repayment enough
for the labour of days.

* * * *

The Christmas box and the Santa Claus figure can be filled with candies and nuts, as described in this article.

Even the pictures that hang on your walls can take on a new Christmas look with some white paper and paint. How to do it is explained in the text.

A cornucopia is quickly made by fastening a 6" paper lace doily with a staple and covering this with a fancy sticker. These may be used for candies, table raisins, nuts, or for fingers of Christmas cake and shortbread.

An aeroplane favour is very popular with little boys. It can be made very easily. A stick of gum covered neatly with red or green paper forms the wings; the body is a candy, ½" in diameter and approximately 3" long, wrapped in red or green crepe paper, with one end tied tightly ½" from the end and spread out to resemble the propeller and with the other end forming the tail. Coloured life savers are the wheels, and looseleaf reinforcement stickers are the insignia on each wing. Fine Christmas wrapping string is used to fasten the parts together.

A Santa on skis is another favourite. It is made by using an unshelled peanut for the head, with a face marked on the bottom portion, and a Santa hat of red crepe paper and cotton wool fastened on the top portion. A red-dyed pipe cleaner is put through a hole made in the centre of the shell, drawn down below the face and twisted out to make arms. A second pipe cleaner is used to form the body and legs, and feet are attached to red cardboard skis. One arm is fastened to the string of a candy bag, the other to a place card. Cotton wool whiskers add an authentic touch to the face.

Dining-Room Decorations

When fire prevention rules exclude the use of paper streamers and other decorations from the dining-room, windows can be painted to add greatly to the spirit of Christmas.

Large windows are best suited for this type of decoration. No artistic ability is required—merely intelligence, enthusiasm, a supply of poster paint in the basic colours, and some inexpensive paint brushes.

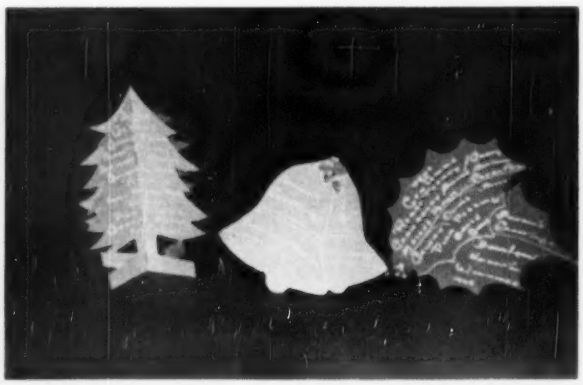
It is first necessary to choose a suitable design, or part of a design, from an old Christmas card. This has to be enlarged (wrapping paper will do for this) to fit the window to be painted and an outline of the design should be pencilled on it. This paper is attached to the outside of the window and is used as a guide in painting the glass. The original picture is used to outline the colour scheme. The paper is, of course, removed when the painting is completed. After Christmas, the paint comes off easily with a little water, cleanser, and elbow grease.

If there are no suitable windows on which to try your artistry, a similar effect can be gained by painting Christmas pictures on heavy white paper which is fastened to the glass of pictures hanging on the wall (see picture). Colour can be added by covering the original frame with red and green crepe paper.

Tables are made attractive with white table cloths (or sheets), fancy serviettes, crackers, holly, and table centres of fruits and nuts set in a basket or bowl trimmed with red or green cellophane or tissue paper.

Christmas trees can be made of vortex drinking cups painted green and sprinkled while wet with epsom

(Concluded on page 91)



These three attractive menus are very much in the spirit of Christmas. A description of how they can be made is given in the accompanying article.

Selection Organization and Control of the MEDICAL STAFF

Part II

Donald R. Easton, M.D.,
Superintendent,
Royal Alexandra Hospital,
Edmonton, Alberta.

THE number of standing committees will depend on the size and organization of the hospital.

Executive Committee

The executive committee is composed of a chairman, vice-chairman, secretary-treasurer, and six members of the attending staff. They are elected annually, usually from the heads of departments, including the pathologist, radiologist, and superintendent. This committee acts in an advisory capacity to the superintendent by handling all medical and administrative problems and, generally speaking, passes on all questions relative to the welfare of the hospital before they are submitted to the whole staff for consideration. Also, in our hospital, they act as a program committee. This group should be thoroughly familiar with the by-laws and regulations of the hospital and should be prepared to support the superintendent in enforcing and carrying out these rules.

Intern Committee

The intern committee, being a very responsible group, should consist largely of the heads of departments. Its function is to act as intermediator between the medical staff and the interns and residents. It should organize the teaching of interns and handle all matters of dispute between the medical staff and the interns. I think it is wise for this committee to have monthly meetings with the interns. This maintains a close liaison and makes for good work.

Legislative Committee

This is another very important committee which is responsible for drawing up all the by-laws and for keeping the staff informed in regard to changes. At the present time, with many hospitals revising their constitutions and by-laws, this committee will find that it has a very strong commitment in this position.

Training School Committee

The training school committee should assist the supervisor of the training school and the superintendent of nurses with the selection of trainees. In addition, it may act as an intermediator between the medical staff and the training school office in matters of dispute which arise between the nurses and the doctors.

Diabetic Committee

This committee should co-ordinate and systematize the treatment of diabetic cases in the hospital as there are many varieties of treatments, particularly in open hospitals. This group can so organize the work that uniform and satisfactory treatment can be carried out. The committee should perfect instructions as to what should be done when a diabetic coma case is admitted to the hospital.

Cancer Committee

The cancer committee should be responsible for the supervision of the treatment of cancer. In provinces where there is a provincial cancer clinic, it should also be the go-between in matters of dispute between the doctors and the cancer clinic.

Fracture Committee

It is the duty of this committee to assume responsibility for the treatment of fracture cases. The fracture committee in our hospital has recently instituted a procedure which I think is of maximum importance. Thursday morning between 8:00 and 8:30 all fracture cases of the previous week are reviewed by the committee and other members of the staff who care to attend. As a matter of fact, all the doctors who treated these cases during the previous week do attend, and also many others of the staff, as they find it to their advantage. The organization is quite simple. A book is kept by the x-ray department in which are listed the fracture cases of the foregoing week. The day before the meeting the films are drawn and made available, and they are generally reviewed by the chairman appointed for the following morning. At the meeting the films are shown and each case is thoroughly discussed. Frequently the attending physician receives valuable advice from the orthopaedic specialists and the general surgeons who are present. I am sure that the whole treatment of fractures has improved in the hospital since the initiation of this procedure. The patients themselves are not brought to the fracture rounds. Following the rounds the resident assumes the responsibility of relaying the comments of the fracture committee to the charts. This forms a permanent record and is also good advice to the attending physician.

Operating Room Committee

This committee is responsible to the superintendent for the proper running of the operating room. In my hospital it also approves the purchase of all equipment for the operating room. The chairman of the committee is the chief of surgery. The committee discusses all matters of dispute between the nurses, anaesthetists, and the attending physicians in the operat-

(Continued on page 72)

An address presented at the A.C.S. sectional meeting held in Winnipeg, April, 1950.

A pharmacist reports on a new germicidal soap

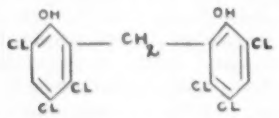
THE STORY OF G-11

F. D. Buck, Phm.B.,
Chief Pharmacist,
Kingston General Hospital,
Kingston, Ontario.

EXTENSIVE studies carried out since 1944 by researchers have revealed that a new synthetic phenol, called G-11 or Hexachlorophene, when incorporated into certain soaps gives a non-irritating product which will maintain an exceedingly low bacterial population on the skin of those who use it. Further, it was found that the routine washing with a 2 per cent G-11 type of soap exclusively induced the production of a lower resident count within two minutes than did similar washing using an ordinary soap for twenty minutes. Seastone *reported that the compound G-11 when incorporated into soap will, when proper attention is given to details of concentration and length of exposure, make the use of both scrubbing brush and somewhat irritating alcohol rinses unnecessary for the preparation of the surgeon's hands and arms.

It is ill-advised, however, to use a G-11 soap in wounds or to follow it with an alcohol rinse, since this process extracts the substance from the skin. The product itself is difficult to incorporate into formulas and should be purchased in its finished form from the manufacturers who have the necessary equipment to compound the soap properly.

Chemically this new compound is 2, 2' dihydroxy—3, 5, 6,—3', 5', 6' —Hexachloro-diphenyl-methane, and has the following formula:



Among the first articles on this subject that came to the attention of the department of pharmacy at the Kingston General Hospital was an excellent one on "Hexachlorophene (G-11) as a Skin Germicide" which appeared in the *Bulletin* of the American Society of Hospital Pharmacists (March-April, 1949, Volume 6, No. 2). We set out to ascertain if G-11 were available in Canada, by contacting the Canadian associate of one of the American firms mentioned in the above article. By August 11th, 1949, we were introducing the use of G-11 on a trial basis in the operating room area. By the following November its acceptance was general in this part of the hospital and as a result we were buying G-11 in 45-gallon drums. No special biological methods were employed to test this soap, as all this had been done countless times before by many research teams; rather it was a test to see what routine could be established to best suit our needs. Since the acceptance of this material in the operating room as a scrub-up soap, it has been found to be entirely satisfactory with no cases of dermatitis traceable directly to G-11. G-11 is a "hypo-allergnic" substance and several cases of dermatitis which had followed the use of the previously supplied soaps were found to disappear.

How to Use It

The routine established is simple —the surgeon each day washes his hands for two minutes, brushing his nails only, then rinsing, et cetera. This procedure is followed by the total scrub—between cases a wash of one and a half minutes is the rule. A wash of six minutes is advised for operating-room personnel, other than surgeons, to offset the possibility that they had not already "scrubbed" that day or on the previous day. No alcohol or any other rinse is used. The amount of time thus saved is astonishing, to say nothing of the saving of "wear and tear" on the surgeon's hands. Now most of our surgeons are using the G-11 soap in their offices and homes to keep the amount of bacterial flora on their hands as low as possible.

Experimental Procedure Used

When the use of G-11 was satisfactorily accepted in the operating room, the thought naturally occurred to the department of pharmacy that the obvious "follow-up" was to advise the same procedure on all the wards and private floors. Thus the surgeon who used G-11 in the operating room would not be forced to lessen its accumulated value by scrubbing with other types of surgical soap when doing routine dressings on his rounds. It was also thought to be a decided advantage to the surgical nurses in saving time spent on scrubbing.

After several meetings with our administrative heads and the supervisor of nursing, the routine use of surgical green soap was discontinued on all the wards and private floors as of the first of June, 1950. This necessitated a small supply of surgical green soap on all "prep" trays for those who still wished to use it for that purpose and the purchase of a synthetic detergent powder for the cleaning of certain utensils. However, after a trial period, this change has gradually been accepted and is now beginning to have the desired effect. At times it seemed difficult to impress on those concerned that it was to be "hands off" the G-11, except for its express purpose. Our efforts have been successful and, although costs are still higher than is desirable, a tapering-off is obvious.

Cost

The cost of a G-11 soap in its full strength of 2½% is relatively 1¾ times that of a good grade of surgical green soap. But when diluted as recommended, that is, 1 part base to 3 parts water (¼ of 1% G-11 to soap solids) it is not much more than diluted surgical base green soap. Its obvious advantages should offset any

(Concluded on page 96)

""Surgery, Gynaecology, and Obstetrics", March, 1947.*

A jolly group of Canadians enjoying the Monday reception which was held at the recent American Hospital Association convention in Atlantic City.

Standing: George Bartel, St. Mary's Memorial Hospital, Montreal; H. H. Browne, Herbert Reddy Memorial Hospital, Montreal; George Masters, Royal Jubilee Hospital, Victoria; Gilbert Turner, M.D., Royal Victoria Hospital, Montreal; John Neilson, M.D., Hamilton General Hospital, Hamilton; J. E. Sharpe, M.D., Toronto General Hospital, Toronto.

Seated: Gerald La Salle, M.D., Royal Victoria Hospital, Montreal; Martha Nephew and Myrtle Lambert, both of Cornwall General Hospital, Cornwall, Ont.; and Stanley Martin, Toronto East General Hospital, Toronto.

Do You Want a Course in Hospital Administration?

In announcing the formation of a Committee on Education of the Canadian Hospital Council, in a previous issue, reference was made to a proposed course in hospital administration. Wherever it has been discussed, the principle of the proposal has received enthusiastic endorsement. The point has been reached, however, where the definite opinion and wishes of the whole hospital field in Canada must be determined.

The project envisaged is an expensive undertaking involving several full-time and part-time staff and a considerable investment in equipment, library extension, et cetera. It would be unwise to set the complicated machinery involved in motion unless it were certain that a real demand existed for the facilities of such a course.

The following is a very brief review of the main elements of the proposal:

The course would be of 2 years' duration involving 2 "winter" sessions on the extension principle, by correspondence, each followed by an intensive 3 or 4 week "summer" session of lectures and demonstrations at one or more university centres.

Initial enrolment would be limited to a maximum of 40 students per year. In establishing entrance requirements, educational background would be secondary to experience in the hospital field and demonstrated ability and interest.

A nominal annual tuition fee of $40.00 or $50.00 (covering a small fraction of the actual cost) would be charged and, in addition, the student would have some expense for supplies, text books, et cetera, and would be responsible for room, board, and transportation in attending summer sessions.

No reference to the content or detailed arrangement of the course, nor to the required inter-relationships with other agencies, is made in the foregoing. Many such details, of necessity, remain to be worked out by the Committee on Education. What the Committee wants now is the *opinion* of every interested person in the hospital field as to the *need* for such a course and, in particular, the *demand* existing and the number of individuals who would apply for enrolment in it.

Express your views in the form of a brief letter to the *Secretary of your own provincial (or regional) hospital association or conference.*

Write—right now! The Canadian Hospital Council and its Committee on Education are ready to proceed. Your response will govern the action they take.

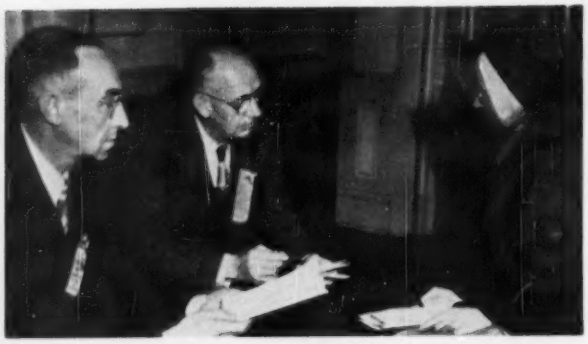
Canada Year Book Now Available

The 1950 edition of the Canada Year Book is now available for distribution. This publication is obtainable from the King's Printer, Ottawa, at a price of two dollars per copy. Paper bound copies can be purchased for one dollar per copy by bona fide teachers, university students, and ministers of religion. The number of these copies is restricted and applications, together with remittances, should be addressed to the Dominion Statistician, Dominion Bureau of Statistics, Ottawa.

Spirit of Co-operation

Marks Annual Meeting of

Saskatchewan Hospitals



The Nominating Committee in action: J. P. Peters, Nipawin; E. G. King, Lloydminster; Mother Mann, Regina.

HOSPITAL people from all parts of this mid-prairie province gathered in Saskatoon on October 11th and 12th for the 32nd annual meeting of the Saskatchewan Hospital Association. Registration was the largest ever, with an enrolment of 164. Informative addresses and lively discussions touched upon every aspect of hospital life with the vital interest of all delegates centred upon the provincial Hospital Services Plan. Very much in evidence was the fine spirit of co-operation which exists between the Plan and the hospital association. This was stressed by Dr. H. E. Baird in his presidential address, and by Dr. F. D. Mott, Acting Deputy Minister of Public Health.

Hospital Services Plan

Dr. Mott reviewed the 4-year history of the provincial hospitalization plan and outlined ways and means by which it could be improved. He said the plan faced three major challenges, although its success as a social experiment was already well-established. These challenges, he pointed out, are the elimination of unnecessary admissions and needlessly long stays in hospitals, the acceleration of efficiency in local hospital administration, and the improvement in the quality of service given to patients. Dr. Mott also enumerated three major accomplishments: the removal of the economic barrier to proper hospital treatment; the success in stabilizing local hospital financing; and the proof that a compulsory hospital insurance scheme can work.

Speakers' Parade

In a report made on the progress of the Provincial Health Survey, S. N. Wynn, Yorkton, reviewed the activities of the organization and spoke of a master hospital plan which would be made public in a few weeks. This plan, designed to expand and integrate hospital facilities, is to be presented to the provincial government for endorsement and later to the federal government for approval.

Reverend H. L. Bertrand, S.J., President of the Catholic Hospital Council of Canada, chose "We Make People Happy" as his topic. One way hospitals can accomplish this, according to Father Bertrand, is to spend money wisely on essentials such as better professional services which will raise the quality of care, rather than on luxurious suites and ornate entrances. He also suggested that open hospitals should make every effort to include general practitioners in the hospital family.

Dr. G. G. Ferguson, Registrar of the Saskatchewan College of Surgeons, thought that the hospitalization plan should be given more government publicity especially in the matter of limitations and restrictions. Too often, he said, patients did not understand "what is paid for and what isn't". On the whole, Dr. Ferguson stated, the medical profession endorsed the plan although some doctors were not in complete agreement with all its details.

At the banquet, guest speaker, Dr. Harvey Agnew, reviewed the accomplishments of the Saskatchewan association during the last twenty years and then predicted what the next twenty years would

—*Photos courtesy Star Phoenix*

"According to what we have here . . .", says Secretary-Treasurer John Smith, Yorkton, to Percy Ward, Vancouver; President H. E. Baird, M.D., Regina; G. G. Ferguson, M.D., Saskatoon; G. W. Myers, Regina.

bring. He envisaged the spread of health schemes across the country as well as more regionalization of hospitals. He also anticipated the increasing use of the practical nurse to carry out many of the duties which are taking up the time of today's graduate nurse. At the conclusion of his address, Dr. Agnew was presented with a lovely painting of the Qu'Appelle Valley, in appreciation of his services to the Association.

Addresses were also given on nursing questions such as, a program for nurses' aides, and post-graduate clinical education.

There were numerous discussions about details of the Health Services Plan such as the new payment system which has been designed to keep down occupancy and avoid overcrowding, and the problem of tax delinquents. At all times, representatives of the plan attempted to clarify any details which might be misunderstood and did much to continue the feeling of good will existing between the plan and the hospitals.

Resolutions

A resolution was passed to the effect that the provincial government be urged again to impose a tax on all areas at present outside union hospital districts. It was also agreed to ask the Planning Commission to try to enlarge the rural hospital districts of the province since a considerable amount of rural land adjacent to hospital areas is not paying anything towards the capital cost of these hospitals.

Resolutions were also passed expressing appreciation to various organizations. The Sun Life Assurance Company of Canada was thanked for its valued assistance to the Canadian Hospital Council in past years and was requested to continue its support. Hospital auxiliaries were given formal appreciation of their contributions as was also the Canadian Hospital Council, especially for making possible the presence of Dr. L. O. Bradley and Mr. Percy Ward at the convention. Formal thanks were tendered to the exhibitors, to the Executive of the Association, to management of the Bessborough Hotel where the convention was held, and to all others responsible for the convention arrangements and for the comfortable facilities enjoyed by delegates.

The Convention recommended that the Executive of the Association together with the Saskatchewan Registered Nurses' Association draw up a salary schedule showing minimum and maximum salaries for nurses, as well as semi-annual increments. All hospitals are to use such a schedule in hiring nurses.

It was also agreed that the Executive of the Association should appoint a special committee to discuss, with the Saskatchewan Hospital Services Plan, the possibility of setting up a central supply de-

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Deep in discussion: Don Schlamp, Melville, and R. J. Hunter, Prince Albert.

Catholic Hospitals of Saskatchewan Convene

Members of the Catholic Hospital Conference of Saskatchewan gathered at St. Paul's Hospital, Saskatoon, on October 10th, for their 8th annual meeting. A well-planned program of addresses and discussions claimed the attention of all delegates throughout the meeting. Sister Marguerite Mann, President of the Conference, presided at the business sessions of the meeting.

Interesting talks were given by Reverend H. L. Bertrand, S.J., President of the Catholic Hospital Council of Canada, who stressed the "Duties of Doctors in Conforming to the Principles of Ethics", and by Dr. L. O. Bradley, Executive Secretary of the Canadian Hospital Council, who spoke on the "Responsibilities of Increasing Hospital Utilization".

Reverend John Flanagan, S.J., Executive Director of the Catholic Hospital Association of the United States and Canada, discussed how religious personnel could best be used in hospitals. His viewpoint was that sisters in hospitals, when trained and physically able, should devote their time to bed-side nursing, rather than spend it either as administrators or in menial or unnecessary duties. In this way, he thought, they were best able to practise Christian charity as well as to help relieve the present nursing shortage. Father Flanagan, along with other speakers, also pointed out that there were many opportunities for sisters to undertake nursing responsibilities in the community, in home care, and other programs. In fact, throughout the meeting, it was stressed that charitable service must be extended to certain individuals of the community, such as, the handicapped, the aged, and the chronically ill.

Sister M. Crescentia, C.S.M., Director of Social Services, Regina, presented an excellent analysis of social service within the hospital setting, and a round table discussion on methods of improving the catholic spirit in hospitals was led by Reverend D. J. Mulcahey, St. Paul's Cathedral, Saskatoon.

New Officers

President: Sister M. Pulcheria, Humboldt.

Vice-president: Sister M. Laurentia, Moose Jaw.

Secretary: Sister M. Emelie, Humboldt.

Councillors: Sister Anacleta, Estevan; Sister Bezaire, Saskatoon; Sister Philippe de Cesaree, North Battleford; Sister Anne Keohane, Tisdale.

Nursing Committee: Sister Hildegarde, Humboldt.

Legislative Committee: Sister M. Farley, Grey Nuns' Program, Regina.

Fifth Western Canada Institute
— *Another Bang-Up Success*

SOME two hundred administrators and trustees were registered for the full course at the 1950 Western Canada Institute, held in Winnipeg, October 16th-21st. As many more attended whenever their time allowed.

The large convention hall at the Fort Garry Hotel was filled to capacity each day (some even had to stand) as students and visitors heard addresses by experts in the various phases of hospital work. The program, planned by a committee representing all four western provinces, was largely arranged by the host province. In view of the fact that all Manitoba hospitals have had a grievous year because of flood conditions, it seems almost miraculous that such an impressive program could have been realized. It was not only well arranged but carried through with utmost smoothness. For this the committee in charge deserves the gratitude of all Western Canada. Much credit must go to Allan McLean of the Childrens' Hospital, who took over chairmanship of the committee when Donald Cox left for British Columbia in June. Mr. McLean built on the groundwork laid by Mr. Cox and was ably assisted in the detail work by the secretary of the committee, Paul D. Shannon, who is permanent secretary of the provincial hospital association. Other members of the committee were: Dr. Harry Coppinger, Dr. W. R. Dunlop, Frank Foster, Judge J. M. George, A. Hodgkinson, F. W. L. Judge, J. M. McIntyre, G. Pickering, F. Silversides, and Dr. O. C. Trainor.

Dr. Angus McGugan, the co-ordinating chairman, introduced the week of study by giving a brief outline of the course at the opening session. The list of speakers was imposing and included many guests from outside the western provinces. Among the latter were: Graham L. Davis of the Kellogg Foundation; John Storm, editor of *Hospitals*, Chicago; Miss Dina O. Bremness, R.N., Glenwood Community Hospital, Glenwood, Minn.; Sister M. Loretta, St. Mary's Hospital, Duluth, Minn.; Dr. Harvey Agnew, Professor of Hospital Administration, University of Toronto; Austin Evans, of the University of Iowa Hospitals, Iowa City, who spoke for Gerard Hartman of the same institution; Ray Amberg, University of Minnesota Hospital, Minneapolis, Minn.; Arthur J. Swanson, Toronto Western Hospital, Toronto; H. Gordon Hughes, Chief, Hospital Design Division, Department of National Health and Welfare, Ottawa; Dr. L. O. Bradley, Executive Secretary, Canadian Hospital Council, Toronto.

The week's work was planned more or less in convention style, with formal lectures followed by discussion periods and intervals to visit the exhibits. Since the program was so long and varied it is possible here to touch upon only a few of the subjects studied. Many of the addresses will appear as articles in subsequent issues of this journal.

Judge George, President of the Manitoba Hospital Association, confers with Institute speakers Dr. Harvey Agnew of Toronto; H. Gordon Hughes of Ottawa; Percy Ward of Vancouver, and Dr. Morley R. Elliott of Winnipeg.

Hospitals as Health Centres

Dr. Morley R. Elliott, Director of Health Services, Department of Health and Welfare, Manitoba, presented a stimulating and forceful address on the "Relationship of the Hospital to the Public Health Service", outlining the ways in which practical results can be achieved through closer co-operation between the two in serving the public. He emphasized that "the border lines between curative and preventive medicine are fading out and any attempt to fix such boundaries is no longer realistic". Dr. Elliott urged that "medical care should include all the various types of facilities and services necessary to meet the needs of both sick and healthy" and indicated, with just pride, that in Manitoba several local health departments are now housed in district hospitals. Also, as new district hospitals are planned in that province, provision is made in the original design for this joint housing. Dr. Elliott recommended that in planning a new hospital, office space for local physicians be included as a convenience to both.

Under the title, "Investigate Before Investing", Graham L. Davis

of the Kellogg Foundation expounded the importance of a careful survey to ascertain community needs before expending vast sums on hospital construction. He referred to the Michigan survey and explained how hospital services were being integrated in that state. Mr. Davis showed slides of several new smaller hospitals which are, in accordance with the present trend, health centres and include doctors' offices as well as ancillary services. Several of these operate as branches of large metropolitan hospitals. The various plans shown prompted many questions from the floor and there was lively discussion on the possible relationships between large and small hospitals.

Administration

With his usual outstanding eloquence, Percy Ward of Vancouver neatly wrapped up that widespread and weighty subject, "Hospital Organization and Management", in one brief address. He discussed the "vital parts" of a hospital in allegorical terms — a method most thought-provoking and, on occasion, amusing. Mr. Ward likened the administrator of the hospital to the brain, because it is his function to receive messages from the rest of the body (or organization) and to direct the movements of the numerous parts. Because the responsibilities of that key person are somewhat arduous, the speaker stressed the importance of having a strong administrator. He warned trustees against trying to bolster up a weak administrator, since such efforts would only make him weaker.

John Storm, editor of *Hospitals* and also of *Trustee*, opened his address on the "Duties and Responsibilities of the Hospital Trustee" with the definition: "Traditionally . . . the ideal trustee is wealthy and generous, tolerant, understanding, patient, wealthy and generous, tactful, alert, interested, well informed, and wealthy and generous." "However," said Mr. Storm, "if we can't find one with all these qualifications, we usually settle for one who is merely wealthy and generous." In more serious vein, the speaker outlined the less spectacular assets desirable in a trustee,

Canvassing the Corridors for Candid Shots

No, it's not a tug-of-war . . . Judge George and Allan McLean open the exhibits.

A tête-à-tête to compare notes (or plans?): R. M. Clements of S.H.S.P. and Edith Pringle of B.C.H.I.S.

A bevy of Sisters.

offering his opinion that a new trustee should write an examination at the end of one year—a procedure by which his interest in, and knowledge of, his responsibilities could be gauged. The speaker stressed the fact that good hospital care is rooted in well-formulated policies on the part of the board of trustees, and that no administrative magic can produce results if strong and consistent policy is lacking.

The subject "Duties, Responsibilities, and Problems of the Nurse Administrator of the Small Hospital" was covered in a series of three papers.

Speaking about the 10-bed unit, Ina Broadfoot, Reg. N., Director of Nursing Service, Manitoba Division, Canadian Red Cross, expounded the almost incalculable number of duties expected of the matron in such an outpost. These ranged from nursing, cooking, bookkeeping, purchasing, plumbing and electrical repairs, to general public relations. She spoke with appreciation of the assistance given by local women's aids and made a very constructive suggestion—Why not a men's aid? A group of men, any one of whom could be called upon in an emergency to do minor repair jobs, would save the matron of such a hospital untold worry and work.

Dina O. Bremness, Reg. N., of Glenwood, Minn., discussed administration problems in a 30-bed hospital, and Mrs. Edith Pringle, Reg. N., Vancouver, spoke from the viewpoint of the nurse administrator in a 100-bed institution.

In a brilliant dissertation entitled "New Lamps for Old Ones", Dr. A. C. McGugan, Edmonton, reviewed developments in medical science during the past 50 years and indicated the changes in hospital design and administration which have grown out of those advances.

Training of Administrators

This subject was covered by Dr. Harvey Agnew, Professor of Hospital Administration at the University of Toronto, who forecast a time in the not-too-distant future when certification would be required of all hospital superintendents. It is already so for most other

skilled groups working in the field and in the State of Minnesota superintendents even now come under such a ruling. Those with successful experience qualify, while all new administrators must either have acceptable training or considerable experience as assistants.

Dr. Agnew commented upon the two-year course given for the past four years at the University of Toronto, the course directed by Rev. Hector Bertrand, S.J., President of the Catholic Hospital Council, and the new one at the Vancouver General Hospital which consists of two years of practical instruction. Among other sources of administrative education he mentioned the administration institutes held in the West, in Ontario, Quebec, and the Maritimes, as well as the various journals, texts, reports, and conventions. Yet all these, he said, are not the final answer. More must be done to encourage those now in the field to raise their qualifications. The speaker then asked Dr. L. O. Bradley, Executive Secretary of the Canadian Hospital Council, to explain the course of home study plus summer sessions which the Council hopes to organize. (See page 39). The audience was asked to indicate how many would be interested in taking such a course; the fact that from 40 to 50 people responded would point to the immediate need for this type of training.

Observing the crowds stream forth at the Institute: Graham L. Davis of the Kellogg Foundation, Dr. L. O. Bradley of the Canadian Hospital Council, and Allan McLean, Winnipeg, Chairman of the Program Committee.

Ironing out some weighty problems: Dr. W. R. Dunlop, Deer Lodge Hospital (left) chats with members of the program committee, Paul D. Shannon, and Frank Silversides, Winnipeg.

Records, Business, and Budgets

Beginning with admission procedures and forms, Dr. D. R. Easton of Edmonton emphasized the importance (both to the hospital and to the patient) of keeping meticulously accurate medical records. To stimulate general discussion, Dr. Easton distributed to the audience complete sets of record forms as used in his own hospital, the Royal Alexandra. These were examined with interest and vigorous questioning ensued.

Dr. H. E. Baird of Regina spoke on "Insurance for Hospitals", stressing the responsibility of the governing board to see that (a) the hospital is insured against every hazard to which it is subject, and (b) that sound coverage is obtained at the lowest possible cost. The address covered the two main classifications of insurance which a hospital needs, i.e., fire, and public liability.

The hospital business office, its functions and its place in the whole organization, was the subject of a practical discourse by Paul Shannon, consulting accountant for the Manitoba Hospital Association, while R. M. Clements, C.A., of the Department of Public Health, Province of Saskatchewan, presented a masterly treatise on the "Principles, Preparation, and Use of Budgets". In summing up, Mr. Clements clinched his arguments with the following remark: "Normally the time expended by the administration on preparing a budget will save endless hours of work and worry which inevitably result when a business enterprise tries to stumble along without systematically reviewing the path it is taking, or in other words, proceeds with its eyes shut. Budgeting is good business, good administration, and good common sense."

Hospital Design and Organization of Services

In dealing with the planning of small hospitals, H. Gordon Hughes

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Associated Hospitals of Manitoba — New name adopted at annual meeting

Manitoba Hospitals Urge Grants on Cost-of-Care Basis

THIS year's annual meeting of Manitoba hospitals (Oct. 20-21) was necessarily brief, since it followed the week-long Institute. The convention consisted of an official dinner on Friday evening, October 21st, followed by business sessions on Saturday.

In bringing greetings from the province of Manitoba, at the dinner, the Hon. Ivan Schultz, K.C., Minister of Health and Public Welfare, spoke in appreciative terms of the work of the association. He emphasized, however, that the association has a heavy responsibility not only in serving the public through its individual hospitals but also in "selling" that service to the public and to the government through public opinion. If hospitals are to be treated fairly by governments, he said, the people at large must first appreciate the service rendered and approve or promote any steps taken by the government. He suggested that hospital people, pre-occupied with their own tasks, were all too apt to neglect the opinion of the public at large and only through public demand can financial support be achieved.

Judge Milton George, in his presidential address, emphasized that the work performed by hospitals is the responsibility not only of hospital people but of every individual citizen. He spoke in glowing terms of the support given by many organizations and the press but admitted that voluntary hospital officials had shown some timidity in "selling their wares". To that extent, those who have built up a service "not secondary to any public service" are responsible for any lack of public interest. He promised that requests for increased government assistance should, in future, be based upon fact and supported by public demand. He expressed gratitude to Mr. Schultz for the increased interest shown by his department in hospital problems.

In summing up the year's activities, Judge George thanked all those who had given so freely of their time in arranging the Institue, discussed problems arising from the May flood, described the development of regional councils throughout the province, and the setting up of permanent association headquarters. He also reviewed the whole financial problem, indicating wherein the various government agencies had failed to meet the cost of care, and emphasized the importance of a re-allotment of federal grants in order that a share of the construction funds might be used for nurses' homes or service departments. The president's address was later condensed for broadcasting purposes so that the public at large might listen.

Ernest Gagnon
Honorary Life Membership.

Honorary Life Membership

On this occasion, officers of the association saw fit to confer three life memberships in reward for public service. Life membership is an honour not conferred lightly by the association and so the event was marked by due ceremony. Recipients were:

Ernest Gagnon, St. Boniface, who for long years acted as secretary of the association, performing a "Herculean task" (in addition to another full-time position) for a very slight honorarium;

Walter Bell, Souris, who had been treasurer of the association since early days and was lauded as being extraordinarily adept in collecting dues;

Donald M. Cox, now with the Hospital Service Commission in British Columbia, who was largely influential in organizing the first Western Canada Institute in Winnipeg four years ago and was always a pillar of strength to the local association.

Mr. Gagnon most graciously and wittily expressed his appreciation of the honour thus bestowed upon him, recalling entertaining episodes during the course of his work in the field. Since Walter Bell and Donald Cox were unable to be present, their certificates will be presented at a suitable time.

Resolutions

On Saturday, after due discussion, resolutions were passed to the effect that:

Whereas the Manitoba Hospital Service Association has submitted a proposal which allows for the prepayment of hospital care for all citizens of Manitoba, the Association urges on the Minister of Health and Public Welfare a careful and sympathetic consideration of the proposal and respectfully suggests that it merits adoption by the Government of Manitoba.

It was also resolved that the Association recommend strongly the abolition of the present municipal rate for indigents and that in future the municipalities pay the total hospital account, using the M.H.S.A. rates as a standard.

Whereas hospitals are dissatisfied with payments, for care of patients, received from the Work-

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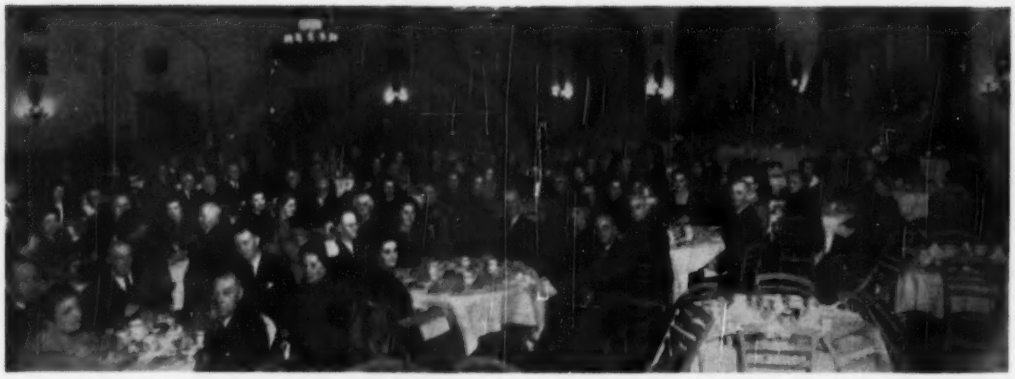

Hospitals of British Columbia Hold Lecture Sessions and Convention

CONVENING in the crystal ballroom of Hotel Vancouver, October 24-27, the British Columbia Hospitals' Association held its 33rd annual meeting. As has become customary in that province, the first two days were devoted to pre-convention lecture and discussion periods — highly valuable as educational media— and the final days were given over to the regular business sessions of the association.

Representatives of the Hospital Insurance Service took an active part in the program and, as a matter of course, some phase of the various relationships between the hospitals and the H.I.S. entered into and coloured many discussions.

At a symposium on small hospital problems, T. D. Musto of the Hospital Service Division, H.I.S., emphasized that the purpose of that division is to provide a consulting service for hospital administrators and assist them wherever possible in problems of management. Miss E. E. Nordlund, Reg.N., of the same division, concentrated on the nursing service, pointing out the necessity for sound personnel policies, including comfortable accommodation for nurses, stressed the importance of staff conferences, and reminded her audience of the heavy responsibilities carried by the night nurse. K. R. Martin, personnel consultant, H.I.S., offered assistance in setting up personnel policies and indicated that his department could be helpful as a source of information concerning prospective employees. He also discussed at some length the administrative problems involved in dealing with labour unions and warned hospitals against granting salary increases which might upset the wage level in the surrounding community.

Edith Pringle, Reg.N., Inspector of Hospitals, spoke on "Preparing the Patient for Discharge" and pointed out that this procedure rightly begins at the very moment of admission. Every patient, she said, is a potential long-stay case unless careful investigation is carried through as to the cause of admission and home conditions.

The new hospital construction branch, recently established by the Hospital Insurance Service, was discussed briefly by A. E. W. Pitkethley, who offered the assistance of this branch to committees planning new hospitals or additions to existing structures. He deplored the tendency in some communities to lower standards of construction due to shortage of funds, as poor initial construction can only result in waste.

The Hospital Insurance Commissioner, L. F. Detwiller, reviewed the organization of the insurance service and explained the new system of payment to hospitals which is being instituted. This will be a matter of direct payment and collection. Group payment has caused some difficulty because of the migrations of many labourers and it is hoped that the new system will result in more efficiency and economy. A method known as cyclical billing will be used, i.e., bills will be divided into six groups and sent out at different dates, so that there will be a steady flow of bills going out and a steady flow of payments coming in.

An interesting feature of the convention was a demonstration of nursing care in the treatment of poliomyelitis (anterior), directed by Mrs. Joyce Campbell, Nursing Arts Instructor, and demonstrated by four senior students of the School of Nursing, all of the Vancouver General Hospital.

This year, for the first time, the convention dinner was sponsored by the British Columbia Association of Hospital Administrators—an occasion which was thoroughly enjoyed by all. The guest speaker was Donald Cox, formerly of Win-

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Seventh Annual Meeting
Associated Hospitals of Alberta.

Alberta's Dollar-a-Day Plan
to be Made Available to All

MORE than 250 delegates and guests were registered at the Palliser Hotel in Calgary for the seventh annual convention of the Associated Hospitals of Alberta, October 26-28. The Associated Auxiliaries of the province held their annual meeting concurrently so that representatives of voluntary women workers were able to attend many of the sessions of the larger convention. Visitors included: Leonard Goudy, Chicago; Gordon Hughes, Ottawa; Rev. Hector Bertrand, Montreal; Dr. Owen Trainor, Winnipeg; and Dr. Leonard Bradley, Toronto. The provincial government was also well represented.

In his address at the opening session, Dr. W. W. Cross, Minister of Health for Alberta, indicated that the government hoped next year to make the dollar-a-day hospitalization plan available to all residents, whether they are ratepayers or not. The next step would then be to establish reciprocity between all hospitals in the province to cover emergency cases and cases referred from one hospital to another. At the present time a little over 50 per cent of the population is covered by the plan.

In outlining the plan at the same session, John McGilp, Assistant Director, Hospital and Medical Services Branch, Department of Public Health, explained that while the plan now applies to ratepayers only, it is expected that legislation at the next sitting of the House will make it possible for the government to pay the special grant (50 per cent of the basic ward rate after the fee of $1.00 has been deducted) on behalf of non-ratepayers as well. Under the proposed legislation, non-ratepayers would purchase a ticket from the hospital district at a flat rate to be determined later and thus avail themselves of the privilege of $1.00-per-day hospitalization. It was pointed out with satisfaction that there is no abuse of the Alberta plan since the small cash payment required of patients acts as a deterrent.

Varied Program

Many other subjects of widespread interest were covered in the course of a closely-packed program —only a few of which can be mentioned here.

In discussing the care of the chronically ill, Sister Beatrice of Banff asked government assistance for such patients, either at home or in well-equipped institutions, since they are a group who must depend more and more on the public for support and care. Moreover this care should be given, wherever possible, through specially designed hospitals, skilled nursing attention, supervised dietary habits, and the required therapies. Miss M. J. Myles, also of Banff, outlined the part played by the physiotherapist in a co-ordinated plan of rehabilitation.

Lt.-Col. G. L. Morgan-Smith urged that plans be made now for civilian defence and outlined immediate steps which should be taken. A film revealing the devastation in Hiroshima and Nagasaki was shown, with comment and explanation by Dr. D. R. Easton.

Under the heading "Hospital Administration Today" Leonard Goudy of the American Hospital Association discussed the efforts of that association to standardize equipment, supplies, and procedures. He also explained the A.H.A.'s proposal to place the approval program, hitherto carried by the American College of Surgeons, under a joint Commission appointed by his association and certain medical bodies. He assured his audience that under such an arrangement inspection and approval

Officers of the Associated Hospitals of Alberta discuss plans for the coming year. Left to right: President, E. E. Dutton, Lethbridge; Secretary and Treasurer, R. G. Adshead, Edmonton; James Barnes, Calgary; Leonard Wilson, Drumheller; Sr. M. Beatrice, Banff; R. J. McLean, Calgary; S. H. Edwards, Bassano; Dr. D. R. Easton, Edmonton.

would be available to hospitals on application whether or not they were members of the A.H.A.

Mr. Gordon Hughes, in his usual spirited fashion, spoke on modern hospital architecture and Dr. L. O. Bradley discussed the future of voluntary effort.

The Municipal Hospitals Section of the provincial association held a special meeting on October 27th under the chairmanship of C. E. Sissons, of Clive. Five short addresses were featured, with ample time for discussion after each.

Judging from the various expressions, it must have been a good one. Left to right: J. Crower and R. G. H. Wilson, Drumheller; Rev. Hector L. Bertrand, Montreal; Leonard Wilson and G. C. Duncan, Drumheller.

Resolutions

Resolutions were passed to the following effect:

(1) Requesting the association's Economic Committee to make representations to the Minister of Health seeking an increase in the rates now paid to hospitals by the provincial government for hospitalization of maternity patients, old age pensioners, et cetera.

(2) That the association ask the Canadian Hospital Council to make representations to have hospital purchases exempted from any recent or new taxation for national defence or revenue purposes.

(3) That the association in convention approve the principle of pension plans and recommend that member hospitals, if possible, institute pension plans for employees as soon as possible.

(4) That, since facilities for training administrative personnel are practically non-existent in Alberta, and should the correspondence courses to be operated by the Canadian Hospital Council not meet the entire need, the directors of the association be requested to approach the Departments of Health and Education of the provincial government for assistance in setting up, operating, and financing short courses in hospital administration.

(5) That the directors of the association or a committee appointed by them, together with representatives of the Departments of Public Health and of Education, investigate the entire matter of educational requirements for nurse training and period of training, with a view to encouraging more students to enter that profession and accelerating nurse training in general.

(6) That the Economics Committee seek financial assistance from the Departments of Health and Education of the provincial government, for those hospitals which operate training schools for nurses.

Officers 1950-51

Hon. President: W. W. Cross, M.D., Minister of Health
President: Edgar E. Dutton, Lethbridge
Vice-Pres.: S. H. Edwards, Bassano
Secretary-Treasurer: L. R. Adshead, Edmonton
Directors: D. R. Easton, M.D., Edmonton; Rev. Sister Beatrice, Banff; James Barnes, Calgary; R. J. McLean, Calgary; Leonard Wilson, Drumheller.

Visiting the exhibits between sessions at Calgary. Left to right: H. T. Nixon, High River; W. J. Edwards, Calgary; Eleanor Dayman, Three Hills; Isabel Lamont and F. J. Cowling, High River; and R. G. Banks, Calgary.

1951 Institute To be in Edmonton

Under the chairmanship of Dr. A. C. McGugan, Edmonton, a meeting of the Co-ordinating Committee for Western Canada Institutes took place, on October 20, to discuss whether and where another institute might be convened. Those present represented the four western provinces participating in, and benefiting through, these study courses which have been held annually for five years.

It was agreed that past attendance and the interest shown proved the need to continue holding institutes. Moreover, a motion was passed endorsing the principle of having them annually rather than at longer intervals. Members of the committee felt that there would be loss in both interest and value should each province "play host" only, say, once in eight years rather than once in four, as is now the case.

Another motion was adopted, instructing the co-ordinating chairman to invite past chairmen of program committees to make digests of their experiences in arranging an institute. This material is to be compiled and circulated to mem-

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Spiraling Costs — Keynote of O.H.A. Discussions

THE outstanding success of the Ontario Hospital Association's annual convention, held at the Royal York Hotel, Toronto, October 30-November 1, marks another milestone in the Association's history of conventions. Noted speakers, stimulating and sometimes controversial subjects, thoughtful planning by those responsible, all contributed to making this a most worthwhile meeting for the delegates who attended, not only from Ontario, but from both eastern and western provinces. Registration was close to 2,000, of which 1,600 were delegates.

The President, Dr. W. Douglas Piercey, in his report referred to "our greatest national economic asset as the health of our nation". He emphasized the desirability of a hospital public relations program to acquaint the public with the hospital's services as a diagnostic and educational institution, and as a therapeutic centre.

Delegates were pleased to see Dr. Fred Routley, who was absent last year due to illness, again taking part in the activities. As Executive-Secretary-Treasurer of the Association, Dr. Routley in his report summed up the activities of the past year. The Association has been working closely with the Prime Minister and the Minister of Health regarding the financial problems facing the hospitals and the spiraling costs. The government, he said, was sympathetic and was making careful studies with regard to what assistance should be rendered. Dr. Routley expressed satisfaction with the new "package plan" for prepayment of both hospital and medical care. This plan has been worked out by the Association, in co-operation with the Ontario Medical Association, and is now being offered to the public. The Association, he stated, has just completed one of its busiest years. The sections, too, were becoming more active each year, particularly in attempting to solve the many problems that are facing the hospitals.

The breakfast meeting of the Women's Hospital Aids Association was well attended. Mrs. T. J. Lytle, president, conferred life memberships on Mrs. F. W. Routley, Mrs. G. H. Agnew, Mrs. A. M. Huetis, Miss H. T. Meiklejohn, Miss Bertha E. Pickles, and Miss Pearly Morrison.

The Honourable Dr. MacKinnon Phillips, newly appointed Minister of Health for Ontario, at a luncheon on Monday, paid high tribute to Dr. Routley for his work with the Association over the years, and also spoke highly of the work being done by the department of health. Stating that he realized high costs were presenting a problem to hospitals, he quoted figures showing that while the number of people hospitalized during the past ten years has doubled, hospital costs have quadrupled. He said the Department was working on a solution to the problem of high operating expenses and that "our hospital system depends and must continue to depend on every type of voluntary support".

John R. Marshall,
New O.H.A. President.

Highlighting Dr. Phillips' address was his proposal for a "five-unit program" for hospital care. The first unit would be the local general hospital which would house all the special services and would include an out-patient department. Diagnoses would be made and patients assessed in this unit. If they were in the acute category they would receive treatment but, if not, they would be moved to the appropriate institution.

The second unit would be a rehabilitation or convalescent centre, the third would be the chronic unit and would include the aged, incurable, and perhaps the handicapped, such as the blind, deaf, et cetera. The fourth unit would be the university or highly specialized centre, of which only three or four would be necessary in Ontario. The fifth unit would be the home. If necessary, patients living at home could go to the hospital or the rehabilitation centre for treatmen.

Public Relations

A panel of speakers examined the subject of public relations from the viewpoint of the Association, the hospitals, and the press. Dr. Fred W. Routley, Executive Secretary, and Kenneth C. Cross, Director of Public Relations, outlined the activities of the association in this regard. Mr. Cross spoke of the necessity of classifying your public and of determining their immediate requirements. An association must realize, he said, that people require information, education, co-operation, and inspiration.

R. J. Weatherill, Superintendent of the St. Catharines General Hospital, and William M. Gray, member of the Board of Trustees of the Public General Hospital, Chatham, expressed the hospital's conception of public relations. Mr. Weatherill said that a hospital should try to tell

A Volume of Friendship

This beautiful leather bound "Volume of Friendship" is a compilation of letters written by friends in the hospital field to Dr. Frederick William Routley to mark his 25 years of service as secretary-treasurer of the Ontario Hospital Association. It was presented to him at the banquet held on October 31 in connection with the annual convention of the O.H.A.

its story to the community through different agents. A public relations committee, composed of men and women from community organizations and businesses, is invaluable in "selling" a hospital to the community. The women's auxiliary is another ambassador of good will and the employees of the hospital are of prime importance in establishing good relations with the public. Mr. Gray spoke of methods which can be used to interest the community in its hospital and emphasized that the term "public relations" when boiled down simply means good will.

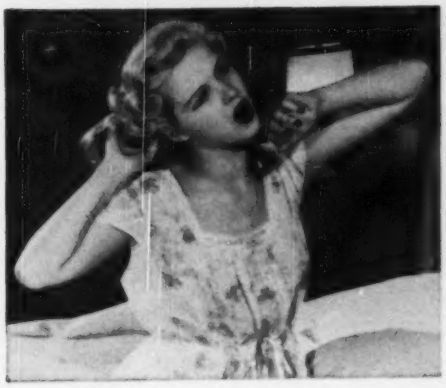
Expressing the viewpoint of the press and radio were Alex Givens of the Toronto Daily Star and Hugh Horler of the McLaren Advertising Co. Mr. Givens defined public relations as doing unto others as you would have them do unto you. Any public relations program must take human dignity into account, and the fact that all people should receive equal care and treatment. Mr. Givens stressed that hospitals should make information more readily available to the press and thought that newspaper representatives should be invited to board meetings. Mr. Horler emphasized the educational possibilities of radio and stressed that radio is not only willing but also able to tell the hospital's story to the public.

Nursing Education

It was evident throughout the convention that the present shortage of graduate nurses and lack of adequate facilities for training purposes were problems of vital concern to the hospital field. These problems were discussed at a general session under the heading of "Hospital Financing in Relation to Nurse Education". John Hornal, Superintendent of the Peterborough Civic Hospital, discussed the necessity of constructing more nurses' residences, since lack of accommodation is a prime factor in the nursing shortage. The cost of constructing and operating schools of nursing can not be borne by hospitals, he stressed. He quoted figures to show that the cost of training a nurse far outweighs the services rendered. Nor should the patient be expected to pay for nursing education, said Mr. Hornal. He pointed out that education as far as primary and secondary schools are concerned is the responsibility of the province and suggested that nursing education should also have such financial assistance. He concluded that it is the duty of hospitals "to inform our government of these facts and to inform the public on these matters, so that our government may have support in a proper course of action".

S. W. Martin, Chairman of the Accounting Section of the O.H.A., examined the cost to hospitals of providing maintenance for graduate nurses as well as providing for nurse education. He stressed that at the present time neither administrators nor nurses have a true knowledge of what it is costing hospitals to supply maintenance for nurses. Also, Mr. Martin pointed out, hospital people in general have little idea of the cost of operating schools of nursing. Contrary to general opinion, most hospitals operating schools of nursing are not doing so to their financial advantage and the present approximate enrolment of 5,000 students is costing the general hospitals of the province some $1,125,000 to $1,250,000. In the absence of any adequate formal plan for financing these schools, the net cost of operating them is assessed against private patient care. Mr. Martin went on to suggest that "since the services of the graduate nurse are utilized by departments, agencies, and hospitals of all levels of government, as well as industries and other commercial enterprises, financial assistance towards the cost of her education could quite properly be undertaken immediately by levels of government in a similar manner as other professional educational programs are subsidized at present". He concluded that "no general financial assistance for schools of nursing will be forthcoming until the hospitals themselves, individually and through their association, provide accurate and up-to-date information concerning operation of their schools. Requests for assistance must be based on facts and made in positive terms as to what form such assistance should take."

Miss Gladys J. Sharpe, Director of Nursing at the Toronto Western Hospital, gave delegates some details concerning the new 24-month nursing course now in force at her hospital. This pilot course, Miss Sharpe explained, was developed to increase the number of nurses without affecting the quality of service. She pointed out that the old apprenticeship method of an earlier age which has been discarded by most professions including medicine still survives in nursing. The advantages of the new course, Miss Sharpe be-



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Among those at the opening ceremonies of the Ontario Hospital Association are (left to right), E. J. Turner, John R. Marshall, Dr. W. Douglas Piercey, Judge J. M. George, His Worship Mayor Hiram McCallum, Miss Lottie Murray, A.J.Swanson, and Dr.Fred W.Routley.

lieves, are threefold. It is more attractive to the student; it is economical and helps to stabilize the nursing staff; and it should result in improved patient care.

Too Luxurious?

Reverend Hector Bertrand, S.J., President of the Catholic Hospital Conference, spoke to delegates about what he termed the present trend toward too much luxury in hospital construction. He warned against the building of suites and ornate entrances. Good medicine, good surgery, and good nursing services, are the necessities to consider in construction, he emphasized.

Government and Municipal Grants

Hospital finance in relation to government and municipal grants was considered in a general session. Max. B. Wallace, Treasurer, Toronto Western Hospital, examined the question of private patient rates. He said hospitals administrators should not apologize for rates now being charged for private and semi-private rooms. Over the past 10 years, rates have shown a steady, reasonable and normal rise, he stated, but services rendered have also increased considerably in the same period.

Dr. W. Douglas Piercey, Superintendent, Ottawa Civic Hospital, gave a brief review of government grants during the 1940-50 period. He stressed the fact that hospitals must get money to meet increasing costs and voiced the hope that the government would consider a program to implement the present system of grants.

R. Fraser Armstrong, Superintendent of the Kingston General Hospital, dealt with municipal grants and rates and discussed ways and means of eliminating wasteful cost items. A considerable expense, he stated, stems from the indefinite features of indigency. This has long been a contentious question for both hospitals and municipalities. The term, "indigency", has never been really defined which makes it difficult to adopt any standard. Thus different interpretations could cause prolonged and costly effort or undesirable and often fruitless court actions. Mr. Armstrong suggested that the O.H.A. ask the department of health to join in a study to reduce waste effort and save money in the matter of indigency.

Arthur J. Swanson, Chairman of the Executive Committee of the O.H.A., appealed to hospital administrators to take a serious look at cost figures and rate structures before they contemplate a rate increase. It is in the matter of ancillary services, he said, that costs are rising so rapidly.

C. G. Cameron, Medical Aid Officer, Workmen's Compensation Board, stressed the co-operation on the part of the hospitals in administering the Workmen's Compensation Act which had been in effect for 33 years. He also spoke of the value of convalescent hospitals and thought t[illegible] when a hospital was planning extensions, it should give services consideration to including a convalescent wing or building.

In a discussion on how to reduce the cost of hospitals to the community, Dr. L. O. Bradley, Executive Secretary of the Canadian Hospital Council, listed ten points which should be stressed. These were a functional, easily maintained structure; modernization of facilities and equipment; better distribution of patients to type or level of hospital required; better administration; better allocation of responsibility for expenditures that are not real hospital costs (for nursing education, research, et cetera); better distribution of beds—in number and location; provision of better personnel through training programs and wider use of male personnel; establishment of a comprehensive rehabilitation program in acute, convalescent, and long term hospitals; return to home care as much as possible; and education of the community to intelligent use of hospital care.

Other Features

John Fisher, C.B.C.'s wandering reporter, was guest speaker at the banquet on Tuesday evening and delighted the audience with his graphic description of some of the little-thought-of points about Canada.

Dr. Fred Routley was the recipient of "A Volume of Friendship" which was presented to him by Dr. W.

(Concluded on page 88)

Other Canadians Honoured at A.C.H.A. Convocation

The following portraits arrived too late to be used in our A.C.H.A. write-up in October. Also, last month, two names were omitted in the listing of those who were admitted to membership in the A.C.H.A.—Harry F. Garwood, Superintendent, Greater Niagara General Hospital, Niagara Falls, Ont., and Harry C. Allnutt, Superintendent, Sherbrooke Hospital, Sherbrooke, Quebec.

Sister Marie de Loyola, Montreal.

Sister Marie Alban, Hull, P.Q.

Sister M. Camillus, Prince Albert, Sask.

Sister M. Aloysius, Prince Albert, Sask.

Sister Catherine de Bologne, Midnapore, Alta.

Sister Jeanne-Mance, Montreal.

Dr. J. Paul Laplante, Ste Anne de Bellevue, P.Q.

Manitoba Hospitals

(Concluded from page 45)

man's Compensation Board of Manitoba and whereas uncertainty exists with regard to the right of the hospitals to collect the difference between present payments and actual costs, the executive was instructed to obtain competent legal opinion on this point and others which may have a bearing on the problem of obtaining adequate payments from the Board.

Whereas retaining an adequate supply of nurses depends in large measure on the provision of suitable accommodation for them, the executive committee was instructed to draft a suitable resolution for presentation to the Minister of National Health and Welfare, Ottawa, urging on him the revision of the present terms and conditions respecting construction grants, to allow for the inclusion of auxiliary facilities such as nurses' homes.

Whereas it is desirable that all hospitals in the province be members of the Association, the executive was instructed to extend a cordial invitation to the Department of Veterans Affairs to enroll Deer Lodge Hospital as an ordinary member of the association.

Whereas the present fees structure is not adequate to cover the increased activities of the Association, an increase in member hospital dues on the following basis was suggested for consideration: $1.00 per bed for all beds actually set up, excluding bassinets, with a minimum of $40.00 and a maximum of $400.00.

Changes in Constitution

After passing a resolution enabling the association in assembly to waive notice of amendments in the constitution, changes were authorized to the following effect:

1. The name of the association was changed to "Associated Hospitals of Manitoba" in order to avoid possible confusion with the Manitoba Hospital Service Association.
2. The Association of Medical Record Librarians was accepted into association membership.
3. An amendment to meet the change in fees structure.
4. Appointment of Paul D. Shannon as executive secretary on a salaried basis.

Officers for 1951

Honorary President: Hon. Ivan Schultz, K.C., Minister of Health and Public Welfare.

President: Judge J. M. George, K.C., Morden.

Past President: O. C. Trainor, M.D., Medical Director, Misericordia Hospital, Winnipeg.

1st Vice-president: J. M. McIntyre, Secretary Manager, Municipal Hospitals, Winnipeg.

2nd Vice-president: H. G. Prior, Portage la Prairie.

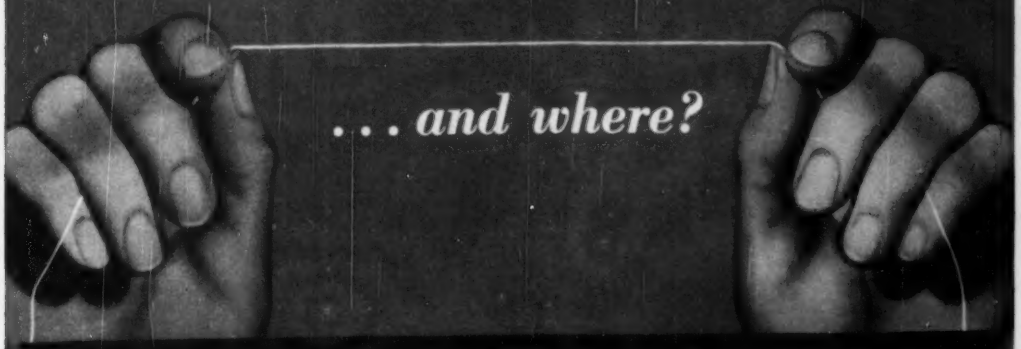
Executive Secretary and Consulting Accountant: Paul D. Shannon, Children's Hospital, Winnipeg.

Treasurer: Allan McLean, Children's Hospital, Winnipeg.

Directors: H. Coppinger, M.D., Supt., Winnipeg General Hospital; W. R. Dunlop, M.D., Deer Lodge, Winnipeg; Miss L. W. Lethbridge, R.N., Supt., Portage la Prairie General Hospital.

Delegates to Regional Councils: Western — George Oliver, Shoal Lake; North-West—J. E. Ramsden, Dauphin; South-West — Frank Foster, Brandon; Centre—R. J. Hood, Carberry; South-Centre—P. F. Barkman, Steinbach; Catholic Hospital Conference — Sister Berthe Dorais, St. Boniface Hospital, St. Boniface.

Which suture will break first–



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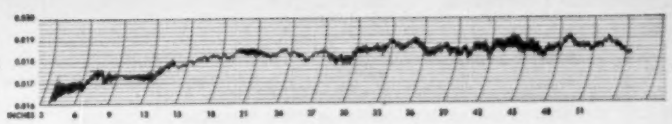

2. Ethicon Tru-Gauged Surgical Gut Suture

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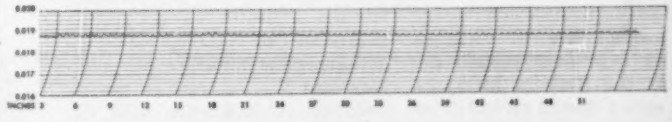
MICROGAUGE SCANS ENTIRE LENGTH OF SUTURE



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LIMITED MONTREAL

An example of visual education: a polio treatment demonstration given by senior student nurses from Vancouver General Hospital added interest to the sessions of the British Columbia Hospitals' Association convention held recently.

B.C. Hospitals Convention

(Concluded form page 46)

nipeg and now Assistant Commissioner in charge of Hospital Services, H.I.S. Mr. Cox chose as his theme the role of the hospital administrator and left with his audience a challenge to aim at better hospital administration and thereby better hospital care. It might be mentioned here that earlier the same day the Hospital Insurance Service gave a special reception for Sisters who were present.

During the convention proper, there was very down-to-earth discussion of financial problems arising as between the hospitals and the B.C.H.I.S., one point at issue being discontinuance of the allowance for depreciation in the daily amount paid to hospitals. In his presidential address, A. H. J. Swencisky outlined the case for the hospitals, while L. F. Detwiller explained the point of view of the H.I.S. The Hon. A. D. Turnbull, Minister of Health, warned against impatience to extend insurance benefits while assuring his audience that the government has no intention of interfering with the autonomy of individual hospitals. Members of the association voted unanimously to give full co-operation to the Hospital Insurance Service.

Discussing new equipment shown at the eye-catching exhibits which were seen at the British Columbia gathering are: Jimmy Ross, Toronto; George Masters, Victoria; H. B. Devine, Langley Prairie, B.C.; Paul Russell, Chilliwack; and Harvey Taylor, Port Alberni.

A new development was the creation of the position of public relations administrator for the association. Percy Ward, who has been secretary for the past two years, was appointed to the above post as well.

Resolutions were passed (a) to the effect that the presidential report be used as a basis for further representations to the government, (b) expressing appreciation of assistance received through the insurance plan, (c) supporting tuberculosis control by use of miniature chest plates on admission, (d) expressing appreciation of federal health grants.

Officers for 1950-51

President: A. H. J. Swencisky, Vancouver

First Vice-Pres.: J. E. O'Mahony, Summerland

Second Vice-Pres.: J. B. Paine, North Vancouver

Secretary and Treasurer: Percy Ward, 129 Osborne Rd., E., North Vancouver.

Chairmen of Divisions: Paul Russell, Chilliwack, (Trustees); Elinor Graham, Reg.N., New Westminster, (Administrators); Mrs. Claude R. Wilson, Vancouver, (Auxiliaries).

International Hospital Federation to Hold 1951 Congress in Brussels

The second post-war International Hospital Congress will be held in Brussels, Belgium, from July 15-21, 1951. The central theme of the congress will be "The Care of the Chronic Sick and the Aged". Among the distinguished speakers will be Dr. E. M. Bluestone, director of the Montefiore Hospital, New York.

Officers of the International Hospital Federation are:

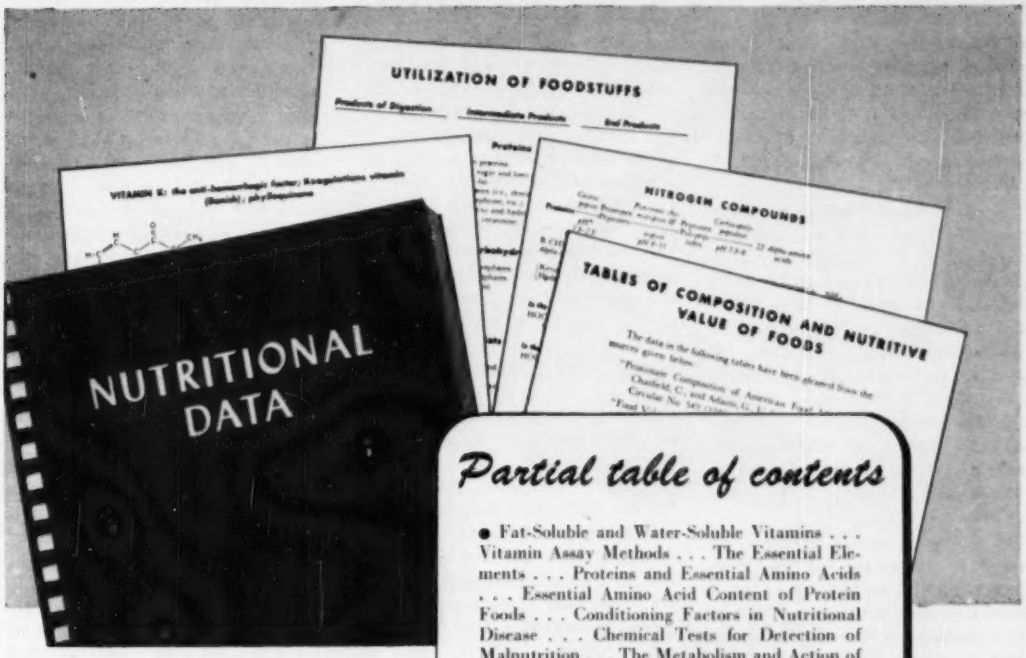
President: Dr. Rene Sand, Professor of Social Medicine, Brussels University, Belgium.

Vice-president: Dr. O. Binswanger, president of the Swiss Hospital Association, director of the Sanatorium Bellevue, Kreuzlingen, Switzerland.

Honourary secretary and treasurer: Capt. J. E. Stone, C.B.E., M.C., F.S.A.A., director, Division of Hospital Facilities, King Edward's Hospital Fund for London, England.

A great step toward independence is a good-humored stomack.

—*Seneca.*



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● Fat-Soluble and Water-Soluble Vitamins . . . Vitamin Assay Methods . . . The Essential Elements . . . Proteins and Essential Amino Acids . . . Essential Amino Acid Content of Protein Foods . . . Conditioning Factors in Nutritional Disease . . . Chemical Tests for Detection of Malnutrition . . . The Metabolism and Action of Foods . . . Dietary Toxicology . . . Human Nutritive Requirements . . . The Diet in Health and Disease . . . Tables of Food Composition and Nutritive Value . . . Selected Bibliography.

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Western Institute

(Concluded from page 44)

of Ottawa showed slides of typical modern exteriors and a number of floor plans. Among these was the fine new hospital at Langley Prairie, B.C. The speaker's comments and suggestions were highly valuable.

R. B. McLean, District Fire Prevention Officer, D.V.A., discussed fire hazards in hospitals under the headings of electricity, inflammable liquids, and smoking. He defined fire prevention as the science of making life and property safe. Mr. McLean gave a highly impressive illustration of the dangers of spontaneous combustion, by combining a little potassium permanganate with glycerine. In about one second flames shot upward amid a billow of smoke.

A colour dynamics engineer, Edward L. McGregor, of the Pittsburgh Paint Company, gave an illustrated lecture on colour therapy in hospitals. It was late afternoon and, if the audience were a little weary, the showmanship used by this speaker effectively startled them out of any casual reverie. No one who was present will henceforth overlook the possible values of colour.

The problem of "Centralization versus Decentralization" of services was explored by Dr. L. O. Bradley, who presented arguments for and against having one consolidated plant rather than separate pavilions, and for and against complete centralization in the controlling of supplies. In the resulting discussion it became evident that the concensus of the meeting favoured centralization for highest efficiency.

Disaster Planning

This topic, which is of vital interest to all hospital people today and particularly apropos in Manitoba this year, was handled with great earnestness by Lt.-Col. G. L. Morgan-Smith, R.C.A.M.C., Prairie Command. We quote briefly: "Many of the implications of preparations against bombing attacks will also have a direct bearing on the civil disasters of fire, explosion, and flood. A city organized for a major bombing attack would also be well prepared to cope with a Halifax explosion, a Red River flood, or a Cocoanut Grove fire . . . While control and co-ordination will be exercised at Dominion and Provincial levels, the ultimate responsibility for a civil defence program will rest with the municipality."

The speaker emphasized the importance of "expandable" hospital and medical care in the "cushion zone" surrounding target areas. The reception zone would be an indefinite area depending on density of population and extent of destruction, e.g., patients from Winnipeg were sent as far as Edmonton last spring. Col. Morgan-Smith indicated that each centre must appoint a civil defence director and provide an adequate staff. He outlined a suggested plan for the medical organization, including instructions for the individual hospital. Much would depend, he said, upon cooperation with the Red Cross and the St. John's Ambulance Brigade. He urged that these organizations extend their first aid training programs now.

The Human Element

Dr. Harvey Agnew outlined the origin of the Hospital Code of Ethics, which was drawn up by the American Hospital Association some years ago and adopted by the Canadian Hospital Council. This code is at present being revised and the new one, to be released shortly, will incorporate more specific administrative principles. The audience was assured that most hospital people need no reminder of ethical principles, but, because they represent a variety of backgrounds, their standards and opinions may differ. For this reason a set guide for all personnel is helpful. Reference was also made to the splendid "Directives" issued by the Catholic Hospital Association.

In the discussion following, speakers from the floor threshed out a whole series of *do's* and *dont's* based upon given situations.

A convincing and eloquent discourse entitled "Personnel Relations Are Public Relations", by Arthur J. Swanson of Toronto, further emphasized the human side of hospital life. Mr. Swanson urged that the old principle of "Do unto others . . . " be the keynote of personnel relations. The spirit of service must be fostered to the fullest extent, he said, and it cannot be purchased. Therefrom will follow high public esteem for any hospital.

Ray Amberg of Minneapolis also touched upon public relations in his lecture, "Patients Are People". Very graphically, he cited criticisms which the average person might make of our hospitals and discussed ways and means of removing any possible justification for these. Mr. Amberg warned of the dangers inherent in allowing the professional staff to become too diluted by lay workers. High standards of care are utterly essential.

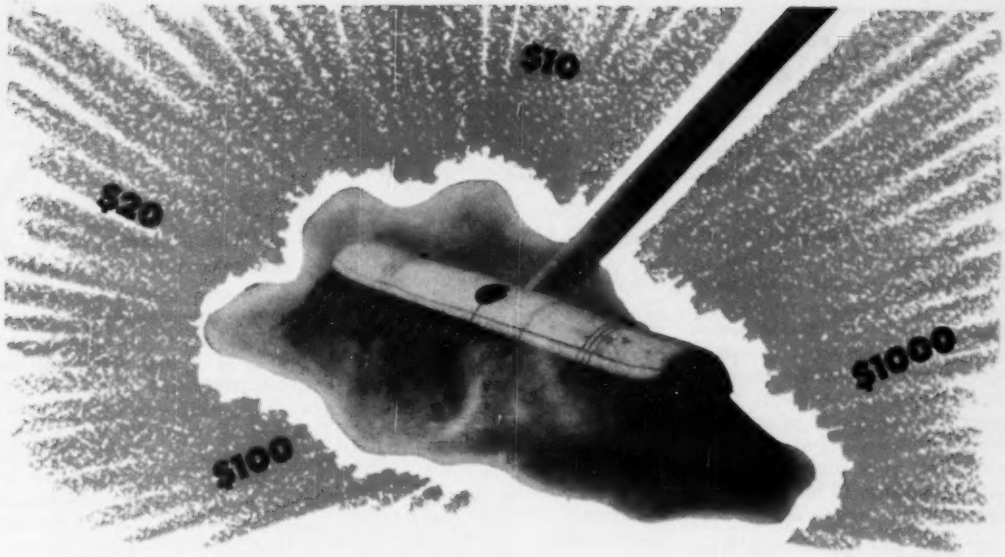
And That Wasn't All

The program offered many bonuses to attending students which it is not possible to cover in detail here. There were the discussions which each day's talks brought forth, and the two very worthwhile sessions called "problem clinics". The latter were highly valuable in that questions were simply dropped into a box by anyone in attendance and then presented to the audience. Opinions on many were widely diversified and led to much interesting give and take, with no lack of oratory.

One afternoon was spent in visiting local hospitals, a choice of no less than six tours having been arranged. About 50 people journeyed as far as Carman, Man., to view the new 44-bed district hospital there. They were much charmed by its design, layout, facilities, and general air of comfort.

Guests and students displayed keen interest in the splendid exhibits arranged by various hospital supply houses. There were, in all, 36 booths and those who provided (gratis) cooling fruit juices, et cetera, had plenty of customers. It was unfortunate that some of the periods labelled "visit the exhibits" were rather brief, because here and there a speaker ran overtime or the discussion was lengthy.

As at the first Western Canada Institute, four years ago, those attending were guests of the City of Winnipeg at an Institute dinner—a gesture of hospitality very much appreciated by all.—*J.F.*



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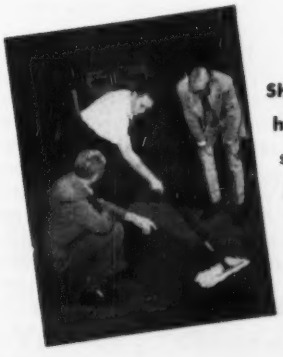

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22

With the Auxiliaries

Saskatchewan Aids Convention Recommends Nursing Scholarship

The ninth annual convention of the Saskatchewan Women's Hospital Aids Association was held on October 11th and 12th at the Bessborough Hotel, Saskatoon, in conjunction with the Saskatchewan Hospital Association Convention. Enthusiastic delegates from over 39 auxiliaries were present. These received a wealth of information from the discussions of the different phases of auxiliary work, the mutual exchange of ideas, and the reports of the various groups.

In panel discussions ideas were brought forth on how to organize an auxiliary, and problems of the small hospital were examined. Other interesting features of the meeting were the addresses of a variety of speakers, including Father Bertrand, President of the Catholic Hospital Council, and G. W. Myers, Executive Director of the Saskatchewan Hospital Services Plan.

Honorary president of the hospital auxiliaries, Dr. Harvey Agnew, visited the meeting and recalled organizing the first provincial meeting in 1941. As a token of appreciation for his interest, Dr. Agnew was presented with a gift by the association.

An increase in the number of auxiliaries was apparent in the many reports from member groups. Mrs. W. Frost of Kinistino, provincial president, stated that there were more than 60 aids in Saskatchewan now affiliated with the association. When the organization was founded in 1941 there were 12 participating groups.

It was recommended at the convention that the association offer an annual scholarship of $100 to the student with the highest academic standing in the province, who is entering the nursing profession. A second recommendation was that a district meeting be held at a central point in each councillor's division once a year, at which each auxiliary in the division would be represented.

Officers for 1951

Honorary president: Dr. Harvey Agnew, Toronto.

President: Mrs. W. B. D. Frost, Kinistino.

1st Vice-president: Mrs. S. S. Alexander, Swift Current.

2nd Vice-president: Mrs. W. S. Pollock, Maple Creek.

3rd Vice-president: Mrs. J. E. Lobsinger, Regina.

District Councillors: Mrs. R. P. Woodfin, North Battleford; Mrs. W. C. King, Estevan; Mrs. R. Wright, Balcarres; Mrs. C. Jose, Dairdson; Mrs. G. Jobson, Ituna; Mrs. J. Balfour, Kipling; Mrs. D. E. Moore, Foam Lake.

—Photo courtesy Star Phoenix, Saskatoon

Chatting between sessions of the Saskatchewan Women's Hospital Aids Association convention were (left to right): First Vice-President, Mrs. L. M. Alexander, Swift Current; Mrs. F. H. Williams, President of the City Hospital Auxiliary; Mrs. W. B. Frost, Provincial President, and Mrs. W. Scott, Secretary, both of Kinistino.

* * * *

Winnipeg Scene of Manitoba Aids Convention

The fourth annual meeting of the Manitoba Women's Hospital Aids Association was held at the Fort Garry Hotel, Winnipeg, on October 20th. The convention was very successful with 42 reports being received from the various member auxiliaries and many new ideas being contributed. Among the interesting topics under discussion was a report from Mrs. J. M. George on the "Manitoba Nurse Recruitment Campaign". Guest speakers included: Judge J. M. George, President, Manitoba Hospital Association, and Dr. L. O. Bradley, Executive Secretary, Canadian Hospital Council.

Officers for 1951

Past president: Mrs. J. M. George, Morden.

President: Mrs. A. E. Hoskin, Winnipeg.

1st Vice-president: Mrs. A. Williams, Seven Sisters Falls.

2nd Vice-president: Miss Edythe Paynter, Winnipeg.

3rd Vice-president: Mrs. R. H. B. North, Carman.

Recording secretary: Miss Christine Macleod, Winnipeg.

Corresponding secretary: Mrs. W. P. Fillmore, Winnipeg.

Treasurer: Mrs. D. Danzinger, Winnipeg.

* * * *

Auxiliary Replenishes Linen Supply

The ladies of the hospital aid to the Boissevain and Morton Memorial Hospital, Boissevain, Man., report that their group has undertaken to replenish the reserve linen supply of the hospital. They are also purchasing mouth-wash cups. A set of dishes for the staff is being given by the Fairburn group of the auxiliary. This organization held its annual fall tea and fruit shower earlier this month.

(Concluded on page 102)

◂ Notes About People ▸

G. J. Bartel New Administrator at St. Mary's, Montreal

George J. Bartel has been appointed administrator of St. Mary's Hospital, Montreal. Mr. Bartel was formerly administrator of St. Barnabas Hospital, Minneapolis, where he served for three and a half years following graduation from the University of Chicago with the degree of Master of Hospital Administration. Before entering the hospital field he was engaged in educational work as a teacher and also as superintendent of schools in Wisconsin. He served in the United States Navy for four years during World War II.

* * * *

New Department Heads at Herbert Reddy Memorial Hospital

The Herbert Reddy Memorial Hospital has announced the appointments of directors for two departments. Dr. Jean-Pierre Jean will head the department of radiology and Dr. Reuben R. Lewis will be in charge of the department of anaesthesia. The former, a graduate in medicine from the University of Montreal, has studied the functions of radiology in diagnosing and treating cancer, in France, the United States, and Toronto. Dr. Jean also served with the R.C.A.F. during the last war. Dr. Lewis, a graduate from McGill University, did post-graduate work at Newark, N.J., and in Chicago. He also served overseas in World War II with the Canadian Army.

* * * *

Dedication Service Honours the Late Dr. A. E. Archer.

The recent unveiling of a stained glass memorial window in the children's ward of the Lamont Public Hospital, Lamont, Alberta, was a tribute from the community in appreciation of the work of the late Dr. A. E. Archer, former superintendent of the hospital. An official announcement of the change in name of the institution to the Archer Memorial Hospital was made at the dedication ceremonies. Dr. Archer had been superintendent of the Lamont Hospital from 1911 until his death in May, 1949. During his career he was twice president of the council of the College of Physicians and Surgeons of Alberta, and was a president of the Alberta Medical Association, the Alberta Hospital Association, and the Canadian Medical Association.

* * * *

Personnel Manager Appointed at Victoria Hospital, London

Victoria Hospital, London, Ont., recently announced the appointment of Mr. Slade C. Nix as personnel manager. This is the first appointment of its kind in the history of the hospital. Mr. Nix is a veteran of World War II, a Bachelor of Arts graduate from the University of Manitoba, and a postgraduate in industrial relations from Queen's University, Kingston, Ont.

Slade C. Nix, London.

Consultant Appointed to Aid Saskatchewan Hospitals

Allan McTaggart has recently been appointed as hospital consultant in the division of hospital administration and standards, Saskatchewan department of public health. His work will complement that of other consultants in such fields as nursing and dietetics. He will visit hospitals throughout the province, on a request basis, making administrative studies which will be submitted to the hospital boards concerned. Mr. McTaggart was formerly administrative assistant to the superintendent of the Royal Victoria Hospital, Montreal. He graduated from the University of Western Ontario, London, Ont., with a Bachelor of Arts degree in 1947, spent a year as business manager of the Kitchener-Waterloo Hospital, and later took a postgraduate course in hospital administration at the University of Toronto.

* * * *

New Superintendent at Cobourg General Hospital

Miss Ethel Clarke, B.A., Reg. N., has been appointed superintendent at the Cobourg General Hospital, Cobourg, Ontario. Miss Clarke has been matron of the new hospital at Cochrane, Ontario. Previously she had been a supervisor at Women's College Hospital, Toronto, and was associate professor of obstetrical nursing there in connection with the University of Toronto. Miss Clarke succeeds Miss C. E. Droppo who has accepted the position of superintendent at the new Trenton and District Memorial Hospital, Trenton, Ontario.

* * * *

J. D. Winslow Awarded Meritorious Medal

J. Douglas Winslow, chairman of the board of the Victoria General Hospital, Woodstock, N.B., has been presented with the Canadian Legion's Meritorious Medal and Certificate of Merit for his service to the Woodstock branch of the Canadian Legion. Mr. Winslow was formerly a vice-president of the Maritime Hospital Association.

23 YEAR PERFORMANCE MAKES FRIGIDAIRE AGAIN THE CHOICE for Elite Café, Saskatoon, Saskatchewan

"23 years ago we bought our first Frigidaire equipment for our restaurant business," say the Girgulis Brothers of Elite Café, Saskatoon, Sask. "Because we enjoyed dependable, economical operation, we naturally turned to Frigidaire's dealer, The J. H. Ashdown Hardware Company, when we decided to air condition our present restaurant. We are more than pleased with the performance of Frigidaire Air Conditioning Equipment as it gives us controlled no-draft comfort cooling and ventilation for our customers. It also increases the efficiency and comfort of our staff. We have recently installed a Frigidaire ice-maker and a Frigidaire compressor for our soda fountain and fish box. We can heartily recommend Frigidaire equipment for all refrigeration and air conditioning needs, for dependable performance, long, economical life."

James Girgulis

Sam Girgulis

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Your local Frigidaire Commercial Refrigeration Dealer has information available concerning all types of Frigidaire refrigeration and air conditioning. Consult him now. Or send coupon today.

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Notes on Federal Grants

Construction

Three Maritime hospitals have been awarded grants for construction. The Cape Breton County Hospital, Sydney River, N.S., will receive $510,000 for a new building to replace the former one which was destroyed by fire earlier this year. It will provide facilities for the treatment of 340 chronic mental patients and when completed in 1952 will have a total bed capacity of 560. More than $28,300 has been granted to the Western Kings Memorial Hospital, Berwick, N.S., for an addition to provide space for a new operating room, a seven-bassinet nursery, and rooms for 20 additional patients.

Alteration to the former nurses' residence at the Hotel Dieu de St. Joseph, Bathurst, N.B., will increase the hospital capacity by 20 additional beds. This project will be assisted by a grant of $20,000.

In Manitoba and Saskatchewan six hospitals have been awarded grants totalling $105,600 to aid in meeting their building costs. At the General Hospital, Brandon, Man., the former suite of the resident physician has been converted into rooms for four patients and the unused isolation hospital has been remodelled for the general medical care of 15 patients. These alterations will bring the bed capacity to 221. About $10,500 will be contributed by both the federal and provincial governments. A grant of $9,000 from federal funds will help construct a community health centre at Pilot Mound, Man. It will have eight beds for patients, a three-bassinet nursery, operating room, and living quarters for the staff. A new wing is being constructed at the Flin Flon General Hospital, Flin Flon, Man., which will add 42 more beds and 18 bassinets. Provincial and federal governments are each contributing $48,000. The new district hospital at Gladstone, Man., has been granted $19,000. It will replace the former building which has been condemned as obsolete and inadequate. The new building will have space for 16 beds, nine bassinets, an operating room, and a dormitory for the staff. In Manitou, Man., a new nursing unit will receive a federal grant of $9,100. When completed it will have space for six beds, x-ray and obstetrical facilities, an operating room for minor surgery, living quarters for the nursing staff, and offices for the local health unit. At Carrot River, Sask., a new 10-bed hospital is under construction and will provide medical, obstetrical, x-ray, and minor surgical facilities. This project will be assisted by a federal grant of $10,000.

Crippled Children

A grant of more than $16,800 will be allocated to expand the services of the Cerebral Palsy Training School and Clinic which is operated by the Junior League in Toronto. This grant will be used to meet the salaries of an additional physiotherapist, another occupational therapist, and two extra instructresses, all working full-time, with a speech therapist and a social worker, on a part-time basis. It will also pay the fees of psychologists, psychiatrists, and other specially-trained persons called in for consultation. About $5,000 will be spent on the special equipment needed for a clinic of this type.

A clinic for children with cerebral palsy is to be established in Edmonton with the aid of more than $25,000 from federal health grants. This will cover the salaries of a part-time director and speech therapist as well as six full-time employees — a physiotherapist, an occupational therapist, a teacher, a brace-maker, a steno-clerk, and a caretaker. More than $10,000 will be spent on special equipment for the medical, speech therapy, occupational and physiotherapy departments. Funds have also been set aside for the clinic's running expenses.

Mental Health

A mental health clinic to serve Northern Ontario is being established at Sudbury with a $14,000 grant. The clinic, to be located in the Sudbury General Hospital, will be staffed by a psychiatrist, a psychologist, a social worker, and a stenographer. The grant will cover the cost of medical and office equipment, running expenses, and the salaries of the staff.

With the continuing expansion of mental health services, a grant of more than $15,600 is being made available to the University of British Columbia to carry on a training course for psychiatric social workers. Approximately 20 students will be trained each year in this course. The grant will pay the salaries of a senior psychiatric case work supervisor, two junior supervisors, and a stenographic staff. It will also meet the cost of equipment needed to get the course under way.

Professional Training

Nine more bursaries have been awarded to residents of British Columbia to help provide better-trained personnel for mental health, cancer, and tuberculosis control work. Two British Columbia teachers will receive a year's training in mental health at the University of Toronto and, on completion of their studies, will act as mental health co-ordinators in their school system. Two staff members from the Essondale mental hospital have been awarded bursaries; one will spend a year studying psychodiagnostic techniques at San Jose State College, University of California, the other will enroll at the University of British Columbia for a year's course in the teaching and supervision of nurses. A staff member from the provincial mental health service will take a year's course in psychiatric social work at McGill University, Montreal.

Three bursaries have been given to help improve diagnostic and treatment facilities for tuberculosis patients; one for a three-months' course in new x-ray techniques at

(Concluded on page 84)

Health Care Plans

New Standards Set for Blue Cross Approval Program

The House of Delegates of the American Hospital Association ratified changes in its Blue Cross Approval Program at Atlantic City on September 17, which will serve to facilitate the administration of the program. The new standards, which become part of the Approval Program, are more specific in terms of requirements for approval and more definitive on certain generally phrased points in the old standards. Much of the American Hospital Association approval program remains the same but the standards and principles adopted by the House of Delegates will take the place of the "Principles of Organization and Operation for Blue Cross Plans" and "Standards of Annual Reapproval of Blue Cross Hospital Service Plans" as described in the approval program under sections II and III.

Summary of New Standards

Of special interest to hospitals are the standards providing that "at least one-third of the members of a Plan's governing board shall be representatives of the contracting hospitals" and, that Blue Cross Plan benefits shall cover on "an average of not less than 75 per cent of the total amount billed for usual and customary hospital services".

The section on financial responsibility of Plans reiterates the former provision that Blue Cross Plans shall produce satisfactory evidence when applying for approval to show that "reserves are adequate to protect hospitals' and subscribers' interests". Plans shall maintain written agreements with a majority of the hospitals in their area so as to be able to furnish benefits to all subscribers enrolled at any given time.

Other provisions in the revised standards call for the maintenance by the Plans of accounting and statistical records as required by the Blue Cross Commission, affirm that Plan employees shall not be paid principally by commission or on a production fee basis and, that board members shall receive no pay for their services as such.

The new standards also provide that Plans "shall participate in all national programs in which at least three-fourths of all Plans, representing also at least three-fourths of the weighted vote of all Plans, are participating". National programs referred to include: transfer of members, hospitalization of members in areas served by another Plan, and uniform enrolment and billing procedures for employees of national firms.

On the whole, the revised approval standards are more specific statements of the responsibility of hospitals and Plans to Blue Cross subscribers and, more concise descriptions of the relationship between hospitals and Plans, subject, in all cases, to local laws or governmental regulations.

The "General Principles and Standards for Approval of Blue Cross Plans", as approved by the House of Delegates of the American Hospital Association, may be obtained through local Blue Cross Plan organizations.

* * * *

Blue Cross Commission Reorganizes Staff Functions

At the September meeting in Atlantic City of the Blue Cross Commission of the American Hospital Association approval was given to the reorganization of staff functions. The services and activities of the commission are now segregated into internal and external operations. This was done to effect an expansion of services to the Plans and streamline current activities. Antone G. Singsen, assistant director of the commission, has assumed responsibility for internal operations which will include personnel, office management, the Inter-Plan Service Benefit Bank, and the actuarial and statistical activities. Lawrence C. Wells, manager of the public relations division, has been named an assistant director to assume responsibility for external operations including public relations, enrolment, government relations, and the hospital relations activities.

* * * *

Home At Last

All departments of the Ontario Hospital Association and its Plan for Hospital Care are now under one roof for the first time in seven years. The Association's building at 135 St. Clair Ave. W., Toronto, part of which until recently had been used by the city for emergency housing quarters, is now being used for the entire organization. This move will facilitate the work of the association which has increased with the rapid growth of the Blue Cross Plan and with the introduction of the new health protection "package" Plan.

* * * *

General Motors Employees Enrol in New Plans

Nearly 8,000 employees of General Motors of Canada at Oshawa, Ontario, and members of their families, were recently enrolled in a health program combining the Ontario Hospital Association's Blue Cross Plan for Hospital Care and Physicians Services Inc. The latter is sponsored by the Ontario Medical Association. The company has agreed to share the costs of the new plan which supersedes their former hospital and surgical program and which was available to employees only. Participation is voluntary but enrolment showed that over 90 per cent of the employees have subscribed.

* * * *

Putting the Bite on Blue Cross

A Minnesota Blue Cross Plan recently had to turn down the request of a subscriber who wanted to lend his membership card to a neighbour who required hospital care — the neighbour had just been bitten by the subscriber's dog!

The small courtesies sweeten life; the greater, ennoble it.

—*C. N. Bovee.*

Provincial Notes

Nova Scotia

SYDNEY MINES. It has been officially announced that a new wing will be added to the Harbour View Hospital and that a major project of renovations will be carried out. The new wing will provide space for 48 or 50 beds and will allow for the addition of a number of new departments. When alterations to the present building are completed, a new x-ray room, laboratory, and children's ward will be provided. Government grants of $200,000 will help finance the modernization and expansion plan which it is estimated will cost $350,000.

* * * *

WINDSOR. The new 40-bed wing of the Payzant Memorial Hospital was officially opened on September 20, by Premier Angus MacDonald. The new wing is a two-storey structure which will be used chiefly for maternity cases and it will adjoin the old 50-bed building. Renovations and improvements have also been made in the old building.

New Brunswick

CAMPBELLTON. The opening of the new 40-bed addition to the Soldiers' Memorial Hospital is expected shortly. This new annex, which joins the main building at the first and second floors, is the former nurses' residence which has been renovated. The nurses had previously moved into their new residence, known as Brebner House.

Quebec

MONTREAL. Plans are being made to build a $1,600,000 addition to the Royal Edward Laurentian Hospital. The proposed building will be adjacent to the present hospital if the by-law, which reserves this section for residential purposes only, is amended. The addition calls for a 100-bed surgical wing which will contain bacteriological and physiological laboratories, and an obstetrical centre. Funds for the project were raised during the Joint Hospital Campaign.

* * * *

ST. JEROME. The cornerstone has been laid for the new St. Jerome Hotel Dieu. It is the first hospital to be erected in a municipality between Montreal and Mont-Laurier. The building will serve 150,000 people in that area and will cost approximately $1,750,000. It will be operated by Les Religieuses Hospitalières de St. Joseph.

* * * *

THREE RIVERS. The $2,000,000 Cooke Sanatorium was officially opened at the beginning of October. This 330-bed institution will serve tuberculosis patients in a district extending from Berthier to Portneuf and from Nicolet to La Tuque. The Order of the Daughters of Jesus will operate the hospital and the medical director is Dr. Hervé Beaudoin.

* * * *

WESTMOUNT. Four newly remodelled and altered departments of the Herbert Reddy Memorial Hospital were officially opened last month. The renovated sections are the obstetrics department, the outdoor clinic, the pharmacy, and a home-care office. The maternity section, which provides accommodation for 37 babies and 34 mothers, is equipped with special bassinets and separate glassed-in compartments for each infant. These projects have been completed at a cost of $100,000. A cancer diagnostic control centre has also been established at the hospital.

Ontario

DRYDEN. An outlay of $750 for modernizing the nursery of the Red Cross Outpost Hospital here has been planned by the Dryden Rotary Club. This expenditure will cover the cost of laying a new floor, painting the interior, purchasing six new cribs, a sterilizer, oxygen tent, scales, and other equipment.

* * * *

MARKDALE. An energetic campaign has been launched throughout the district which is served by the Centre Grey General Hospital to raise funds for the purchase of equipment to provide improved hospital services. It is hoped that the necessary $6,000 will be realized in this drive. This hospital serves a large area, with nine municipalities represented on the board of directors.

* * * *

OTTAWA. A building permit has been granted to the Grey Nuns of the Cross to cover construction of a seven-storey addition to the Ottawa General Hospital. The new section, estimated at a cost of $2,400,000, will be built on Parent street and will connect the present two sections of the hospital. Construction is expected to be completed in the spring of 1952.

* * * *

RAINY RIVER. A new Red Cross Hospital is being built here at an approximate cost of $130,000 to replace the smaller one which is now in operation. It will have 14 beds, a five-bassinet nursery, and equipment to care for medical, surgical, and obstetrical cases. A federal grant of $15,600 will help cover the construction costs.

* * * *

SIMCOE. Tentative plans are being made for a new wing at the Norfolk General Hospital. This will provide space for 37 additional beds, a new dining-room, kitchen, and administration offices. A new boiler room, the first step in this expansion program, will be erected shortly at a cost of $35,000 and will provide heating for a building nearly twice the size of the present hospital. The total cost of the proposed new construction and alterations to the present building is estimated at $500,000.

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TILLSONBURG. Construction of the

new wing on the Tillsonburg Soldiers' Memorial Hospital is going ahead rapidly, but $150,000 is needed to continue the project which is expected to cost approximately three-quarters of a million dollars. It is hoped to raise the necessary sum through local campaigns. The total bed capacity including the new wing will be about 100 beds. It is planned to use part of the old hospital as a nurses' residence, and the remainder for a 20-bed ward for convalescents.

* * * *

TRENTON. Construction on the new Trenton and District Memorial Hospital is proceeding according to plans and it will be opened about Christmas. The refrigerator and automatic elevator are now being installed and landscaping of the grounds is being completed.

Manitoba

FISHER BRANCH. The Fisher Branch Red Cross Hospital recently held an "open house" for the women of the community. With the hospital staff acting as hostesses, eighty guests were shown through the 10-bed modern hospital. Later they were entertained at a tea in the nurses' living quarters.

* * * *

ROLAND. A contract has been signed and the excavation work has been completed for the construction of a four-bed hospital unit here. This is the second unit to be built in the Carman Memorial Hospital District No. 20; the first one, at Miami, was opened early this year.

Saskatchewan

ESTEVAN. An estimated $350,000 addition to the St. Joseph's Hospital is being planned and construction will begin when authorization and financial details have been arranged. It is hoped to increase the present 80-bed hospital to a total capacity of 130. It is expected that the 45-bed extension hospital, which was opened in 1946 at the Estevan airport, will be closed when the new addition is built.

SMEATON. Construction on a $70,000 union hospital at Smeaton, 40 miles west of Prince Albert, is to begin immediately. The new 10-bed hospital will serve Smeaton, half of Torch River, Snowden, and Shipman. At present this district is being served by a six-bed Women's Missionary Society Hospital.

Alberta

FAIRVIEW. It is expected that the interior of the new $100,000 wing at the Fairview Memorial Hospital will be completed sometime in November and will be ready for use at the beginning of next year. A call system has already been installed and the furniture ordered.

* * * *

ISLAY. At a recent meeting of the Islay Municipal Hospital board authorization was given for the purchase of new equipment for the hospital. A new sterilizing unit will be installed and will consist of an autoclave, an instrument sterilizer, and a 10-gallon water sterilizer. The installation will be enclosed and vented through the roof to eliminate excess heat. Alterations for the operating room were also approved.

* * * *

LETHBRIDGE. A new $200,000 addition is being constructed at St. Michael's Hospital here. The new building will provide space for sixty beds and will project east and south from the existing structure in the form of a wing.

British Columbia

KELOWNA. Pending approval by the ratepayers for the construction of a new wing at the Kelowna General Hospital, plans are going ahead to begin work this fall. The wing would provide space for 70 additional beds, of which 38 would be for medical and 32 for surgical cases. New facilities, such as a fracture room, cystoscopy room, and physiotherapy department, are included in the plans. The present operating room, x-ray department and laboratory are to be extended and it is proposed to add new x-ray equipment. Central heating would also be installed.

1951 Institute

(Concluded form page 48)

bers of subsequent program committees for guidance.

Since accommodation for such a large gathering poses a rather difficult problem, much discussion revolved around the question of time and place. Alberta comes next in sequence and those who would carry the responsibility preferred Edmonton for convenience. In order to obtain the best possible working space, it was decided, subject to the approval of the Associated Hospitals of Alberta,* to hold the 1951 institute on the campus of the University of Alberta early in June, a season when the buildings are available. The meeting considered that this setting would also lend an academic atmosphere appropriate to such a study course.

Possible types of program were discussed—workshop, convention, or a combination of these. However, it was not considered feasible to attempt to crystallize the type or style of program until a cross-section of opinion could be obtained from the host association.

Dr. McGugan was re-elected co-ordinating chairman for the coming year.

**This arrangement has now been ratified by the Association.*

New Officers for the C.S.L.T.

The 1951 officers for the Canadian Society of Laboratory Technologists were elected at the annual convention which was held last June at Saint John, N.B. Delegates from Newfoundland to Vancouver attended this very successful meeting.

President: Joseph Scott, Ninette, Man.

First vice-president: Gordon Traill, Pembroke, Ont.

Second vice-president: Miss Elspeth McNelly, Regina, Sask.

Directors: Miss Dorothy Burton, Toronto; Archibald Shearer, Vancouver; Miss Françoise Courtois, Montreal.

Secretary: Miss Helen L. Smith, Hamilton, Ont.

Associate secretary: Miss Kathleen Brown, Hamilton, Ont.

Treasurer: Miss Elizabeth Robertson, Hamilton, Ont.

Associate treasurer: Miss Nona Bruce, Hamilton, Ont.

Medical Staff

(Continued from page 37)

ing room, and irons out the difficulties.

Record Committee

Every administrator is aware of the difficulties involved in getting doctors to complete their charts properly. This is a responsibility which the record committee can assume. In our hospital, each Monday morning, all charts of patients discharged during the previous week are reviewed and summarized on a "medical summary" form provided for the purpose and coded by the interns. These are checked by the residents. Three copies of the medical summary are typewritten and attached to the chart. Any difficulties arising are cleared up at a meeting of the records committee, interns and residents, the following Wednesday morning. Charts are then transferred to the doctors' room where they are placed in slots to be signed by the attending physician. When they have been signed, they are transferred to the record office for filing. The Standard Nomenclature is used. After signing the chart the attending physician keeps one of the typewritten copies, leaving two copies on the chart. This availability of the summary to the doctor greatly increases his interest in the proper completion of the chart.

Nominating Committee

In our hospital this group consists of five staff members appointed by the executive committee. Each November they have the task of nominating the chairman, vice-chairman, secretary-treasurer, the executive committee, the heads of staff and alternates, and also the assistants to the heads of staff and alternates. At the same time, they review the standing of all the doctors on the staff and make recommendations for the transfer of members of the associate staff to the attending staff and also, if indicated, the transfer from the attending staff to the associate staff or the courtesy staff. Their report is referred to the standing executive committee and, if approved, is forwarded to the main staff meeting to be voted upon. Additional nominations may be made at the main staff meeting. It can be readily seen that the members of this committee carry a great responsibility and are open to much criticism if the report is not generally accepted.

X-ray Committee

The x-ray committee is composed of the radiologist as chairman, a member of the orthopaedic staff, a member of the internist staff, and one general practitioner. Their work consists of making recommendations in regard to the physical set-up of the x-ray department, the purchasing of x-ray equipment, and acting as a liaison committee between this department and the remainder of the medical staff.

Burn Committee

This committee is responsible for the proper handling of burn cases in the hospital. They must make adequate preparations for an emergency, when it would be necessary to care for a large group of such cases.

Library Committee

This group has the task of reviewing submissions by the doctors for new journals and periodicals. In addition, they are responsible for the transcription and filing of suitable articles.

Photographic Committee

The photographic committee is responsible for making recommendations in regard to the purchase of photographic equipment and the physical arrangements of this department.

It will be recognized from the above descriptions that the standing committees have their work cut out for them. Accurate accounts should be kept of all meetings as these committees are appointed by the executive committee at its January meeting and they do change frequently. I think it is wise to have the duties of these committees divided evenly in order to stimulate the interest of your attending staff members. These standing committees are appointed from the attending staff only. As a matter of policy we retain one member of the previous year's committee for the purpose of continuity. Apart from this, we find it advisable to give as many members of the staff as possible an opportunity to demonstrate their interest in the hospital by serving on the various committees.

Control of Professional Work

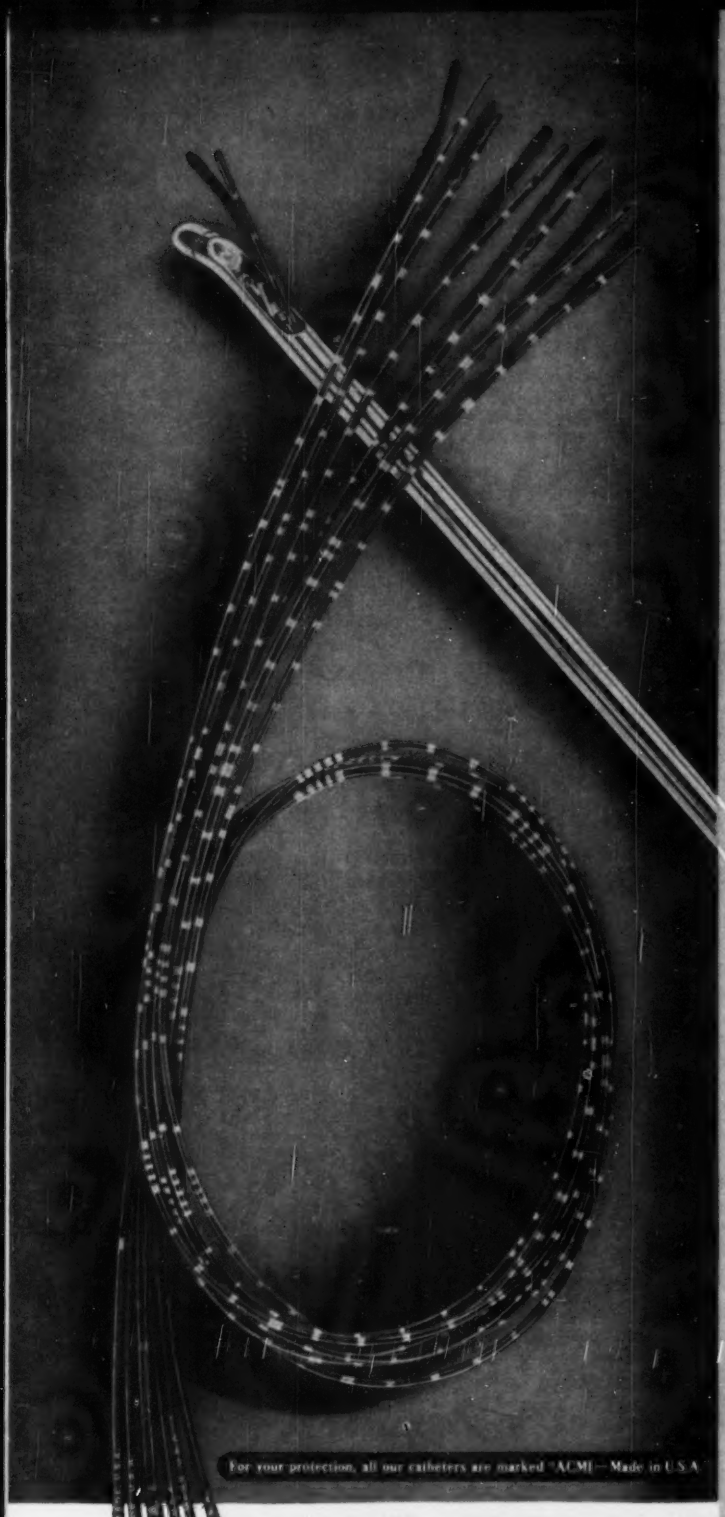
General Measures:

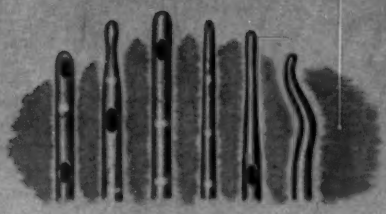
The controlling of professional work in the hospital is one of the most difficult tasks of the administrator. It is much easier to lay down rules than to carry them out. It is difficult to control the doctors without antagonizing them. Certainly, in the case of the lay administrator the situation must be such that they control themselves. I think this also applies to the medical administrator.

The heads of staff and alternates should assume definite responsibility in regard to clinical work in their departments. I do not think that any superintendent should hesitate to call on them at any time to see a case. Once a case is seen by the head of the department the administrator will find the doctor more co-operative in accepting advice than if the medical superintendent steps into the picture and tries to advise him. I think that your interns and residents should feel that they are in a position to go to the superintendent any time they think that a case is not getting satisfactory treatment. If they feel free to do this, and do it, the superintendent receives constant reports regarding the work on the wards. Your resident may not always be right but there is no harm in the issue being raised and in having the head of the department see the case and give his opinion. If the head of the department concurs that the case is not receiving proper treatment, the staff man is contacted immediately and informed of this decision. This method of control is continuous and immediate, and also very satisfactory to the superintendent.

Your pathologist should have the confidence of the superintendent and feel free to go to him at any time he finds that normal tissue is being removed. You are probably aware that many hospitals have "tissue committees" whose work is

(Concluded on page 74)





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Medical Staff

(Concluded from page 72)

to review with the pathologist the tissue removed. This is a very good procedure, but if your pathologist feels free to go to the superintendent any time that he finds normal tissue is being removed, the matter can be referred to the next meeting of the executive committee for action. The committee can then ask the superintendent to write the doctor concerned a letter outlining the situation to him. If corrective measures are not taken by the attending surgeon, the executive committee should have him attend one of their meetings to discuss the matter or refer it to the hospital board for action. In our hospital to date we have not had to refer any of these cases to the board. As they are largely lay members, I think it is better if the matter can be handled by the medical men themselves.

Another method of control is by review of deaths. In our hospital the deaths are reviewed monthly by the executive committee. Following the review, selected cases are examined by the whole staff. This leads to interesting discussions and, as it is kept on a high plane, everyone benefits and no one gets hurt.

As a further means of control, ward rounds are held each Thursday morning from 8:30 to 9:30. At this time any case which is controversial can be readily put on ward rounds and thoroughly discussed by all the staff members present. This is a good corrective measure and tends to bring any problems into the open without anyone being hurt.

I feel that surveys are another means of control and that two or three should be undertaken in a year. Each survey should be done by the resident under the supervision of the head of staff. If you have not already carried out one of these surveys, I would suggest that you start with appendicitis. If you review all the cases of appendicitis in the past year it will be a good start. The second one which is important is a review of all gynaecological surgery done in the past year. This survey material is excellent for presentation at staff meetings as well as bringing out in the open the matter of whether or not any staff member is removing normal tissue. So far we have not been able to complete more than three of these surveys a year but I feel that we should endeavour to have more reviews of this kind.

Specific Measures:

Where a consultation is required in order to comply with the regulations and by-laws of the hospital, no charge shall be made for this consultation.

In all operative deliveries, such as high forceps, versions, et cetera, the reasons for such procedure must be clearly set out on the chart and consultations are advised in these cases.

In the case of the caesarian section, consultations by a certified consultant are mandatory. The consultation sheet must be completed and on the chart before the patient is referred to the operating room.

In every case of therapeutic abortion in which curettage is performed or any other means is used to empty the uterus, the hospital case record shall be signed by the attending physician and a certified consultant.

Sterilization to save a patient's life or to preserve a patient's health is legal. It should be explained to the patient. The written and witnessed consent of both marital partners is required. The necessity for it should be attested to by a written consultation by a certified consultant.

No abdominal operation shall be performed on any pregnant woman without a consultant's attestation, satisfactory to the superintendent, that such an operation is urgently indicated.

Conclusion

In conclusion I should like to state that I realize that this survey of the situation is incomplete. Difficulties are constantly arising in hospital administration for which no precedents have been established. As an example, at their request, a general practitioners' section has been formed recently at our hospital. Now that we have one we don't know what to do with it. The question of how it can be integrated into our present organization will seriously engage our thoughts for the next year.

Hospital administration is an ever-growing and changing subject, not static and fixed, and it behooves hospital administrators to maintain an open and questioning mind if they are going to keep abreast of the times. Just as the science of medicine changes, so will medical organization have to change with it. I should like to add a word of warning about rules, regulations, and by-laws. They should always be interpreted in the light of common sense. While no hospital could operate satisfactorily without them, there are often occasions when they may be broken in the best interests of the patients. In an emergency you should always contact the head of the department concerned. If he thinks an exception should be made in a given case, do not hesitate to make it. Too much rigidity can lead to impossible situations. If your decision is reasonable the doctors will have less fear of regulations and more respect for them and for you.

In all dealings with doctors, may I suggest that you adopt the attitude of a stimulator and co-ordinator. Doctors are all outstanding egotists. They must have plenty of confidence in order to instill confidence in their patients. Do not fight against this egotism but learn to use it to your advantage and to the advantage of the hospital. Make them think it is their hospital and you are trying to help them run it. In this way you maintain their co-operation and goodwill. Furthermore, you will often be pleasantly surprised at how much time and energy they are prepared to devote to promoting the interests of the hospital. A hospital is basically a doctor's workshop. Your measure of success is indicated by the degree of happiness and efficiency found in that workshop.

Hospital Economics

We budget everything on earth
Except mortality and birth;
And yet in spite of all our wit
We end up with a deficit.

—*E. M. Bluestone.*

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Here and There

A Plea for More Care in Medical Writing

IN our high school days, clarity, force, and elegance were taught to be the essentials of English style. Of these, no doubt, the first is paramount. How woefully, then, have most medical writers strayed from the path of their early education! This is true not only of the occasional author, but even of the practised professor of medicine.

It is assumed that all contributions to medical literature are preliminarily screened by editors who are masters in rhetoric and semantics. An examination of articles admitted to print in current medical journals, articles couched in poor, incorrect, unusual, and, at times, even absurd English, makes it doubtful that some of our editors are either employing their vaunted superiority or performing their expected and necessary duty. If it be that additional duties preclude editors from devoting sufficient time to this labour, then there is all the more reason for the medical writer, himself, to be on guard.

Glaring errors of expression appear as frequently in the well edited publications as in the commercial and poorly edited ones. To avoid any appearance of personal criticism, I shall quote from articles without naming authors or journals, for I desire to improve, not to indict. When the title page of one of our outstanding publications exhibits the caption, "Acetic Acid in Metabolism", a very "sour" taste is left in the mouth. Indeed, I am not the first to deplore this seeming deterioration in our powers of expression. One critic has already decried the practice of qualifying absolutes as "essentially normal" or "essentially positive". He says: "Beside the lack of meaning of 'essentially', can you really modify an absolute?"

Here are a few instances of ambiguity, chosen at random. The title of a recent book, *Nursing Pathology*, could refer either to pathology nursing, or being nursed by human, cow, or goat's milk. Actually, this is a textbook on pathology for the use of nurses. An article, headed, "Human Tooth Injuries", if consistent with its title, were more fitting for a dental than a medical journal. The article, however, was concerned with bites inflicted by human beings. "Advances in Head Injuries" might refer to sharper and more lethal weapons or an improved criminal technique, although the author speaks of advances in the treatment of head injuries. A laryncologist referred to his colleagues, and not to a new specimen of Neanderthal man, when he wrote about "ear, nose, and throat men". In all these instances, clarity is sorely lacking.

The desire to appear impressive frequently results in long sentences, burdened by a complex of subordinate clauses, and at times, incorrect grammar, especially in the choice of prepositions. Consider this example: "No correlation exists among the amount of blood lost and changes in haematocrit, haemoglobin, and plasma protein concentration before and after operation". A sharp axe could split this sentence with great benefit and render it readable and understandable. "Mechanism of Radiation Effects Against Malignant Tumours" almost gives the impression that an atomic bomb is being hurled at the tumour. Not "against", but "upon" is the proper preposition. A professor accents ambiguity in the following title: "The Reaction of Tissues Following Infection and Their Place in an Environmental Conception of the Nature of Disease". Except from the pen of a union plumber, the following is unique, "Although in good health, this patient feels that he was better with the ileostomy than since he has been reconnected".

The rule that abstract words cannot have a plural is consistently ignored. "Those patients in whom there were no evidences of inflammation" is a typical example. The physician attempts to become a lawyer, for whom evidence in the generic is sufficient. Other examples are: "The disabilities of the voice and breathing in connection with thyroid surgery vary from slight to tragic" and "Physiologic Therapies in Psychiatry".

In seeking elegance, it is well to draw upon the classic tongues, but only if this be done correctly. An article, "Treatment of Gold Dermatitides", mentions no types of dermatitis. A combination of English and Greek is certain to produce a literary allergic reaction without any antihistaminic remedy at hand. Preventive treatment would be so much simpler. When one writes about "Transfusion preoperatively, intraoperatively, and postoperatively", he is more of a prestidigitator than a surgeon. It is impossible to transfuse *within* ("intra") an operation. He meant to say *during* ("inter"). For him, English, not Latin, would have been the better choice. The use of the "wonder drugs" has resulted in the birth of the word "antibiotic", meaning "against life". Undoubtedly, the popularity and extensive use of these drugs would be considerably curtailed were their action true to their word. Fortunately, the proper word, "antibacterial", is finding its way into medical literature. Finally, to point out the error which is as blatant as it is ludicrous, consider the use of the word "pathology": pathos—disease, and logos—word or study. "There was no pathology found in the abdomen". Instruments and sponges have, unfortunately, been occasionally left "in situ", but one would hardly expect to find a textbook there. One could scarcely refrain from snickering if a noted astronomer were to look up at the heavens on a rainy night in June and say, "Isn't it too bad there is no astronomy out tonight?"

"Ambulatory Proctology" might be an impressive title, but it can only

(Concluded on page 94)

Reprinted from an article appearing in "The Canadian Doctor", by Herbert E. Stein, M.D., September, 1950.

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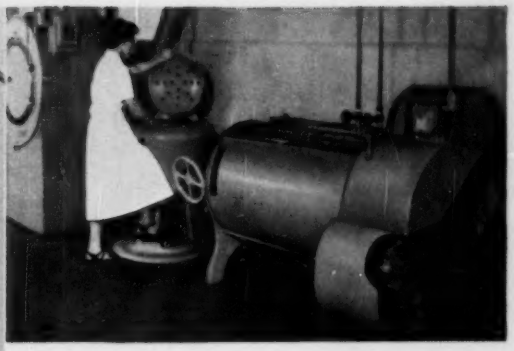
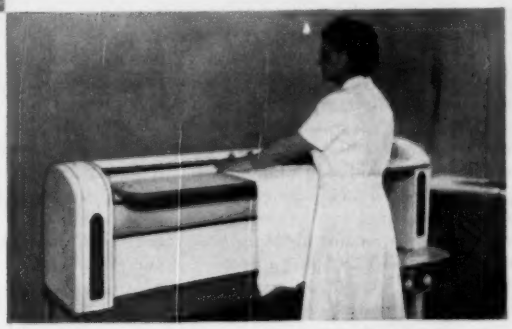


Three of the four Connor Laundry Units in the new Eastview Hotel. In the foreground is the Connor "Series 36" Tumbler Washer with Monel Metal Cylinder. Left to right: Tumbler Dryer — Extractor — Tumbler Washer.



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Prevalence of Plague In Recent Years

THE present decrease of pandemic plague, as revealed by statistics, does not justify the assumption that the disease has lost its power to spread. In fact, in certain countries it has been found that the relaxation of control measures during the war and the postwar period has resulted in extensive outbreaks.

It is true that a large number of areas formerly seriously infested, such as Europe, are to-day free from the disease. In other areas which have been particularly subject to pandemics for centuries, such as Egypt, Libya, and Syria, only sporadic cases now occur. In regions where plague is transmitted by domestic rodents, it is now possible to protect human communities from this scourge by the general application of measures for disinfection and de-ratting. Thus in South America it has been proved that, by employing DDT and 1080 (sodium fluoracetate) it is possible to wipe out plague in the towns and villages. However, while foci of endemic plague still persist, the tenuous barrier represented by quarantine measures will not suffice to ensure absolute protection against the risk of infection. Wild-rodent plague, in particular, which is a potential source of infection for man, continues to spread in South Africa and the Americas and remains a serious menace.

The above observations were made by Dr. P. M. Kaul, Division of Epidemiology, World Health Organization, in an article entitled "Prevalence of plague in the world in recent years". From this article are gleaned some of the following details.

In Africa, the history of plague is very old. Egypt, which has a long tradition of battles with plague, has reported cases nearly every year since 1899. During the 1939 and 1940 epidemics, it was noticed that the buildings where the first cases occurred had pigeon-houses on their roofs. The connection between pigeon-houses and plague may be explained by the fact that rats frequent such places in search of young birds and eggs. Apart from two epidemics in the Casablanca area during the war, Morocco has been free from the plague for some years.

In Kenya, which is a noted East African plague centre, there has been a decrease in the last few years. The number of cases fell from 1,101 in 1925 to 29 in 1948. Uganda, too, has always been considered as a focus of plague; from 1939 to 1942, about 300 cases were reported each year. Then there was a sudden decrease to 19 in 1943, when control measures consisting of inoculation, quarantine, and de-ratting were instituted.

In southern Africa, the permanent reservoir of the disease is constituted by gerbils, which transmit infection to other rodents, which, in turn, transmit it to man. Cases of plague usually occurred at times when mortality was high among domestic rodents following an epizootic among the gerbils. Rodent plague is now endemic throughout the greater part of the Union and is spreading into adjoining territories. However, the incidence of human plague is decreasing.

In Madagascar, the disease is characterized by the high death rate—96 per cent in 1933 and 78.5 per cent in 1947. Preventive inoculation with Girard's EV living plague vaccine is considered very effective. The average morbidity rate per 10,000 inhabitants was 25.3 per year before the introduction of inoculation, i.e., in the period from 1930 to 1934; with inoculation, the annual average rate decreased to 4.6 for the years 1937 to 1941.

Plague still occurs in the United States. It first appeared there in 1900 in San Francisco. Since then, and until quite recently, a number of plague cases have occurred almost every year in California. In all, 503 cases were reported in the States between 1900 and 1944. Since 1924, there have been no epidemics of human plague in the country. The sporadic cases reported were accidentally infected during epizootics among wild rodents. Wild-rodent infection is widely distributed in 15 western states. In 1945, it spread towards the east, reaching Kansas and Nebraska. This eastward advance is a menace, since wild-rodent plague may infect the rodents of the great plains, the Mississippi valley, and the eastern United States. The disease has been found in 40 species of rodents.

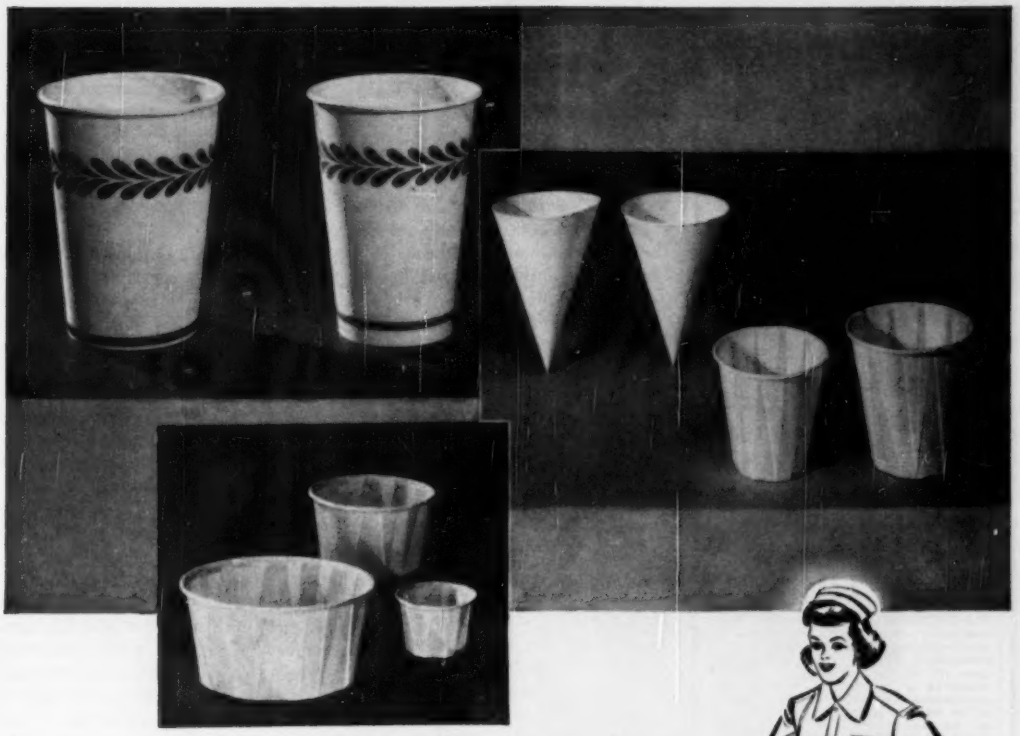
Brazil was one of the first South American countries to be affected by the plague. The disease is now endemic. However, the death-rate, which is relatively low, continues to decrease further following the introduction of sulphonamide therapy, falling to 13 per cent in 1948. Recently, a virulent live vaccine has been used instead of the Haffkine type of vaccine. Peru has suffered most from the plague, but there has been a marked decrease since 1930.

Asia faces one of the greatest problems in the control of plague. In India, where the disease was imported from China in 1896, the number of deaths reached six million for the period 1900 to 1909, then fell to 500,000 for the period 1931 to 1939. The situation became worse in 1943 because of the war, but, since then, the incidence has been steadily decreasing. Java experienced a serious epidemic as recently as 1948, with an extremely high death rate. The situation in China is more difficult to assess because of lack of information, but it is known that the incidence is very high. The construction of the Burma road resulted in the infection of Yunnan from the adjacent endemic focus in Burma.

In the modern world, seaports and airports are important sources

(Concluded on page 96)

From a condensation in the "Chronicle of the World Health Organization", Mar., 1950, of an article by P. M. Kaul, M.D., Division of Epidemiology, WHO.



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Federal Grants

(Concluded from page 64)

the University of Minnesota hospitals; another to take an eight-months' course at the Shaughnessy Hospital, Vancouver, to qualify as a registered laboratory technician with specialized knowledge of bacteriology; a third for six weeks' study in advanced techniques for the treatment of tuberculosis in children at children's hospitals in Toronto and Montreal.

A doctor from the British Columbia Cancer Institute, Vancouver, has been awarded a grant for eight months' post-graduate training which will lead to a certificate in radiology from the Royal College of Physicians. The cost of bursaries for the current fiscal year is estimated at $10,600.

Public Health

The federal government has agreed to meet half the cost of establishing and operating a new health unit for the Muskoka District of Ontario. It will be staffed by a full-time medical health officer, public health nurses, sanitary inspectors, and other personnel. Included in the unit's area are 24 municipalities and three unorganized townships and it will serve about 20,000 permanent residents with a much larger number during the tourist season. The grant of $19,000 will be used to buy equipment and pay salaries. At the same time funds have been allocated to buy a wide variety of health equipment for eight health units in the province: Halton, Kent, Lambton, Leeds and Grenville, Lennox and Addington, Oxford, Porcupine, and York Township. These funds will be used to provide special technical equipment such as, sediment testers, sterilizers, thermometers, baby scales, et cetera. Films and filmstrip projectors will also be purchased to help in health education. The cost of the equipment will be about $6,500.

As part of a national program of research into public health problems a statistical study of the incidence of tooth decay among children is being conducted by the faculty of dentistry of the University of Toronto. The present study is being carried out by a dentist under the supervision of an associate professor of dental public health. Available data will be analyzed to show the quantity of tooth decay and attempts will be made to relate this information to the ages and the tooth surfaces of the children involved. The cost of the research is estimated at $2,700 this year.

Another national health project is a survey being carried out in Brant County, Ontario, to determine the prevalence of undulant fever or brucellosis. This disease is spread to humans from cattle having Bang's disease; thus prevention among humans depends upon the eradication among susceptible animals. The study is being carried out by two veterinarians with the co-operation of cattle-owners and with the assistance of the medical profession.

The federal government has allocated funds from the national health grants to Ontario for continued research into alcoholism. The allotted $10,000 is for the current fiscal year and is a renewal of a similar grant made last year. Further aspects of assistance to the Ontario studies of this subject are also under consideration.

Tuberculosis

The Laval Sanatorium at Ste. Foy, near Quebec City, has been awarded a grant totalling more than $129,000 to help improve its diagnostic and treatment services. In addition to caring for its own patients, it will provide advanced thoracic surgery for the Roberval, Begin, and Lake Edward Sanatoria. Approximately $100,000 will be spent on technical equipment for departments of radiology, surgery, pharmacy, gynaecology, urology, dentistry, and special services. Equipment to be obtained ranges from massive $20,000 x-ray units to bronchoscopy equipment. The remainder of the grant will be used for the salaries of an additional staff. Among the latter will be a doctor to develop a rehabilitation service, another for the hospital's clinic, two welfare workers, three nurses for the surgical department, technicians for the laboratory, x-ray, and surgical departments, and additional clerical assistants.

Correspondence

Chapels in Hospitals

Dear Mr. Editor:

When reading the interesting account of Peterborough's new hospital in the September issue of *The Canadian Hospital* I was especially impressed by the paragraph relating to the chapel. For a long time I have felt that the lay hospitals have overlooked the value of this important item in hospital planning. I doubt if there is a hospital anywhere, operated by a religious order, that is without a chapel. Such chapels are considered an essential part of the building and they are used, not only by the Sisters, but by the staff, by ambulatory patients, as well as members of patients' families.

What better place for the clergy to meet and console families of critically ill patients, or of patients who have died. The waiting room is not a suitable place at such a time. The spiritual side of the healing art is recognized by many physicians and a chapel can emphasize that fact.

Visiting clergy can hold services for staff members whose hours of duty make it difficult for them to attend church services especially in cases where the nearest church is some distance from the hospital.

Belleville General Hospital possesses a chapel and, I have been told, it is in frequent use. With Peterborough we now have two lay hospitals in Ontario thus equipped. There may be others about which I do not know.

With all the new hospitals planned and being built I would like to urge that all building committees consider adapting some conveniently located spot in their hospitals as properly equipped chapels. They will never regret allocating space for this purpose.

Yours very truly,

"O. G. Smith",

Consulting Accountant,
Ontario Hospital Association,
135 St. Clair Ave. W.,
Toronto, Ontario. ●

A man lives not only his personal life, as an individual, but also, consciously or unconsciously, the life of his epoch and his contemporaries.—*Thomas Mann.*

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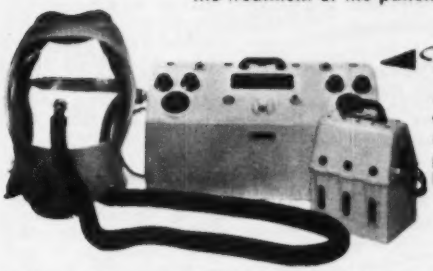

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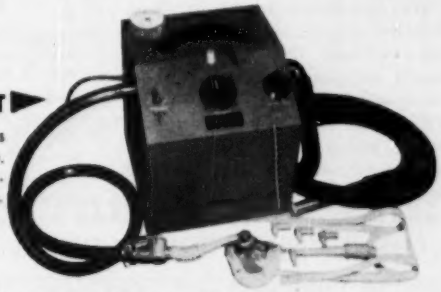

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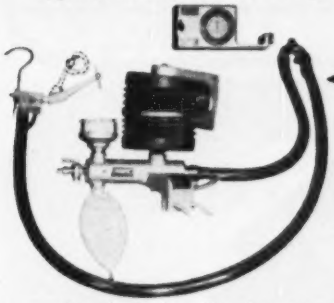

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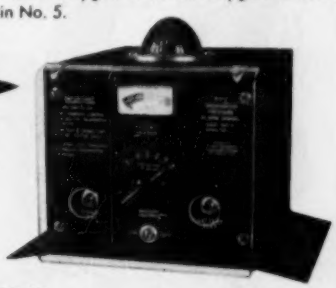
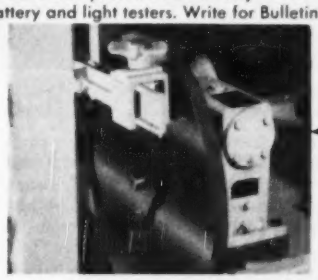


...a safety device for all tank-type or portable respirators. Warns the nurse—not the patient—by flashing a red warning light within 10 seconds of serious loss or failure of pressure due to **any** cause. Includes warning pressure adjustment, battery and light testers. Write for Bulletin No. 7.



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...a refinement of the crank-type bellows actuation on Drinker-Collins respirators. Supplies a more efficient and physiological breathing pattern to the patient. Patients are more comfortable in a cam-actuated respirator. For further information write for Bulletin No. 6.

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O.H.A. Convention

(Concluded from page 52)

Douglas Piercey on behalf of the Ontario Hospital Association. The volume comprises some 100 letters, written to Dr. Routley by individuals in appreciation of his work with the Association during the past 25 years.

Dr. Routley was also the recipient of the George Findlay Stephens Memorial Award, an award established by the Canadian Hospital Council for outstanding service in the hospital field in Canada. The presentation was made by R. Fraser Armstrong, president of the Council, and the citation read by Dr. L. O. Bradley, executive secretary.

No convention of the Ontario Hospital Association would be complete without the exhibitors and nearly everyone took time out between sessions to visit the exhibits. This year there were 97 booths which means that there were 25 more exhibitors than last year and applications are already being received for space for next year.

As at previous conventions, the exhibitors again sponsored a very fine variety show and the enthusiastic and spontaneous applause of the audience indicated their appreciation of this well-planned entertainment.

Addenda

The section meetings, held concurrently on Tuesday, were packed to capacity and these will be reviewed briefly in our next issue.

During the convention an open house was held by the association at its headquarters building which also contains the Ontario Blue Cross Plan offices. Many interested visitors enjoyed the opportunity of seeing the intricate machinery of the Plan in operation.

Officers

Honorary President: Honourable Dr. MacKinnon Phillips, Provincial Minister of Health.

Honorary Vice-President: W. Douglas Piercey, M.D., Ottawa.

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Assoc. Executive Secretary: Arthur J. Swanson, Toronto.

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—*Marianna Korman and Eileen Scott.*

Schools of Social Work Receive Grants

Canada's eight schools of social work are to receive $52,500 from the federal government. This will be allocated on the basis of $1,000 for each school with the remainder being divided according to enrolment. The Maritime School of Social Work, Halifax, will receive $2,390; Laval University, Quebec, $4,690; University of Montreal, $7,310; McGill University, Montreal, $7,150; St. Patrick's College, Ottawa, $2,390; University of Toronto, $12,060; University of Manitoba, Winnipeg, $3,870; and University of British Columbia, Vancouver, $12,640.

The grant arose originally from an unprecedented demand from both governmental and private social agencies for persons professionally trained in social work. The need continues, and in some specialties, such as psychiatric social work, has been deepened by the development of new services financed by the national health grants.

Health Department Expands Indian Health Services

As part of an expansion program for improved medical services to the Indians the federal health department has appointed two full-time medical officers to be stationed at Hazelton, B.C., and Fort Rae, N.W.T. Dr. O. J. Rath, a graduate in science and medicine from the University of Alberta and formerly on the staff of the Charles Camsell Indian Hospital, Edmonton, has been stationed at Fort Rae. The medical officer at Hazelton is Dr. Frederick Raynham, a graduate of the University of London, England, who was formerly on the staff of the Hotel Dieu and the Kingston Military Hospital, Kingston, Ont.

Further construction of Indian health centres is taking place in Ontario and Quebec. The centres at Restigouche, near the Quebec-New Brunswick boundary, and on Walpole Island in southwestern Ontario, are nearing completion. Work is also under way at Pointe Bleue on Lake St. John, Quebec, and at Rupert House on the Quebec side of James Bay. Each centre consists of a dispensary, waiting room, and living quarters for the nurse in charge and her assistant. The Rupert House building also has emergency accommodation for from four to six patients.

And Now . . . . Colour Television

Colour television has entered the medical teaching field at the University of Chicago's cancer research centre. The School of Medicine plans to use it in surgical teaching. This method has many advantages as the television camera will be able to provide details of operations which observers in the amphitheatre are not able to see. Discussions between the surgeon and the observers will be made possible by a small receiver in the surgeon's cap and a lightweight microphone.

Intensely Right

A powerful agent is the right word. Whenever we come upon one of those intensely right words in a book or a newspaper the resulting effect is physical as well as spiritual, and electrically prompt. — *Mark Twain.*

The Month Before Christmas

(Concluded from page 36)

salts. These are set on an applicator or sucker stick fixed in a large gum drop. Several of these on small paper doilies are effective when placed around a fruit centrepiece.

When time and energy permit, and space is available, more elaborate table centres can be attempted. One of the most effective we have seen was a house made by using a cardboard box, approximately 7" by 5" by 5". It was covered with hard icing, white on the sides and pink on the roof. The chimney was built of pastel-coloured, "satin cushion" candies set in the icing, while the door was a bar of plain chocolate with striped peppermint candy sticks on each side. The windows were sheets of glacé set in icing. A tiny toy Santa Claus was on his way down the chimney with his sleigh (made of cardboard, iced and sprinkled with sugar) and reindeer pranced in front of the house. A candy cane picket fence surrounded the house and cotton wool sparkling with artificial snow completed the setting.

The papier mâché cornucopia is another lovely decoration but is only for those who are really energetic and enthusiastic, as it is a "messy" procedure. However, the results are most worthwhile. To make the mâché a large quantity of newspaper is torn into small pieces which are soaked in water for several days until they become mushy. The paper is then drained and beaten until well mashed. A thin paste composed of flour, water, and a small amount of sugar, is mixed well and then added to the paper. The mâché is then moulded over buckram cut to the size and shape desired and left for several days to dry. White paint, sprinkled while wet with tinsel, is put on the outside, and cotton forms a lining on the inside. Now the cornucopia is ready to be filled with fruit and nuts.

And now, we hope you are ready for happy decorating and a very merry Christmas!

Experience, the universal Mother of Sciences.—*Cervantes.*

Without Benefit of Hospital Facilities*

An interesting point about the recent flood is the fact that a quarter of a million people got along quite well for three weeks without the benefit of hospital facilities. There was probably little change in the number of those who ailed and few died at home who would not have also died in hospital. From this follows that patients can be cared for successfully at home even today when technical investigation is regarded as essential for proper treatment and it further follows that, in normal times, many patients do not need hospital beds. To be sure it is much more convenient for a doctor to have his scattered practice gathered under one roof and, in many cases, getting a patient out of his or her home is in itself a therapeutic measure. But now that the old familiar cry "Sorry, no beds" is again being heard in the land, we can help ourselves, the hospitals, and the really sick by keeping at home those who need go no further to get well.

*An editorial appearing in "The Manitoba Medical Review", by J. C. Hossack, M.D., C.M. (Man.), Editor, August-September, 1950.

Larger Quarters for Cancer Detection Clinic

Women's College Hospital, Toronto, Ont., opened new quarters for its cancer detection clinic recently. An old three-storey home near the hospital was converted to provide more space and better facilities. The clinic is on the first floor of the building and consists of five fully-equipped examining rooms, each under the direction of a specialist; 10 dressings rooms; a pleasantly-decorated waiting room; and administrative offices. Space for nurses' quarters is provided on the two upper floors.

The clinic has been operating very successfully since its opening a year ago last April. According to Dr. Florence McConney, Director, 2,145 patients have been examined, and 200 repeat examinations have been made. Applications numbered 41,144 and there is a waiting list of about 2,000—a list that would be much longer if the clinic had not obtained new quarters. About 200 women a month are now being examined. Another advantage of the new quarters, said Dr. McConney, is that it is now possible to do a complete examination in one day, which is particularly important for out-of-town women. The clinic is doing much not only in detecting cases of incipient cancer in apparently well women, but also in discovering symptoms of other unsuspected disabilities.

New Matron for Red Cross Outpost

Miss N. McIntyre assumed her duties as matron at the Red Cross Outpost Hospital, Hudson Bay, Sask., in the middle of October. She succeeds Matron Ratti whose resignation became effective on September 15. Mrs. I. Eye was acting matron until the arrival of Miss McIntyre.

Care in Medical Writing

(Concluded from page 78)

mean that "the study of the rectum is walking about". Aristotle, founder of the peripatetic school, would turn in his grave! Not to be outdone, the word "symptomatology" has found its protagonists, thus: "Comparison of all patients with acute appendicitis with those having urologic symptomatology . . . ". A truly impossible comparison! Consider, also, "sodium pentothal anaesthesia for selected vaginal obstetrics . . . " is defined as the "science of midwifery". To suffix this definition to "vaginal" is meaningless. If we wish to be scientific, we should have to consider uterine, ovarian, and tubal obstetrics.

No amount of academic freedom or common erroneous usage can justify these ambiguities and contradictions. The foregoing are but a few instances of improper English, gleaned from contemporary medical literature, to illustrate some of the more common lapses from literary grace. Since, deservedly or not, we physicians are members of an esteemed profession, respected for learning, it behooves us to state our views and promulgate our teachings and experiences for the benefit of mankind, in clear-cut, accurate, and polished English. The word is to medical science what the scalpel is to surgical art and should be used as precisely, as wisely, and as artistically.

New Cancer Control Clinic Established in Montreal

The first cancer diagnostic control centre in Montreal was officially opened in October at the Herbert Reddy Memorial Hospital. Funds were allocated by the provincial and federal governments for the project with further aid from the Cancer Research Society. The clinic provides facilities for diagnosis of symptoms in all parts of the body and will receive patients only on recommendation of their doctors. The hospital's departments of gynaecology and obstetrics, surgery, radiology, and pathology are co-operating in the operation of the new clinic. Initial interviews and examinations are being carried out in specially reconditioned rooms of the Out Door Clinic once a week. Dr. Malcolm B. MacKenzie, the hospital pathologist, will be in charge of the administration of the clinic.

Hospitalization Tax Unchanged in Saskatchewan

An announcement has been made by the Hon. T. J. Bentley, Minister of Public Health, Saskatchewan, that the hospitalization tax rates for that province will remain unchanged for the year 1951. Only a minor change has been made in the regulations governing the levy and collection of the tax. In the future, Indians who have been off the reservation for 18 months and who no longer receive hospital services from the federal government, can pay the hospitalization tax on a voluntary basis and receive coverage by the Saskatchewan Hospital Services Plan.

The Story of G-11

(Concluded from page 38)

increase in cost. Careful checking of its use in the wards, accurate dilution, and careful dispensing, are those factors which will produce the maximum efficiency expected from this modern skin germicide.

Conclusion

In our department we have also noticed an increased demand for this germicide to be dispensed to patients leaving the hospital who are to return later for operations. It is also requested for patients with various types of skin eruptions and as a general cleaning soap. As a consequence we feel the results have warranted the assumption that G-11 is here to stay and that it should prove a boon to every surgeon, physician, and nurse, in any hospital, large or small.

The Prevalence of Plague

(Concluded from page 82)

of infection. It is believed that all the large ports might soon have been free from plague if the international situation had remained normal. However, because of the war, plague reappeared in several Asiatic and African ports. Following the infection of the Suez Canal and North African ports, the disease made its appearance in a few European ports in the Mediterranean, although no cases have been reported there since 1946.

Saskatchewan Convention

(Concluded from page 41)

pot from which each hospital may obtain supplies on requisition.

Officers

President: H. H. Bassett, Prince Albert.
Vice-president: H. B. Myers, Rosetown.
Secretary-treasurer: John Smith, Yorkton.
Executive: J. C. Saunders, Saskatoon; S. N. Wynn, Yorkton; E. H. Rice, Swift Current; S. Ferguson, Borden; Dr. H. E. Baird, Regina (Ex Officio).

Teamwork for Rehabilitation Plea of Therapist

Dr. A. N. Zinovieff, newly appointed director of the course in physical and occupational therapy at the University of Toronto, emphasized the need for teamwork in rehabilitation when he spoke at the recent annual meeting of the Toronto Association of Occupational Therapy. Dr. Zinovieff stated that to successfully rehabilitate a patient it was necessary to combine the work of skilled doctors, occupational and physical therapists, and social workers. He advised further that it was never too late to begin this work and that it should commence as soon as the acute stage of an illness is past. The experiences gained with injured war veterans had changed doctors' thinking from the terms of an illness itself to the functional results of that illness.

Man is so made that he can only find relaxation from one kind of labour by taking up another.

—*Anatole France.*

Ambassador of Good Will

(Concluded from page 31)

and friends concerning the patient's condition and treatment is a difficult one. In the case of private patients these queries may largely be left to the attending physician to handle but in ward cases a different picture is presented. A procedure worked out by Dr. E. M. Bluestone at Montefiore Hospital in New York has been attracting much favourable notice, (Modern Hospital, May, '49). In Dr. Bluestone's plan the members of the patient's family are given an opportunity to talk with both doctors and social workers at a stated time and place just prior to the visiting hour. The information given to the family is sound and authoritative. It satisfies their very understandable concern and goes a long way toward building up good will for the hospital.

The old perfunctory, disinterested, routine report, "Doing as well as can be expected," has we hope long since been relegated to the discard where it belongs. It is a colossal bluff which tells no one anything, only serves to irritate the inquirer, and may increase instead of allay the anxiety of the family.

The administrator of every hospital should take occasion to impress upon the personnel of his institution, constantly, the real value of courtesy and a spirit of kindliness toward all patients and their families and friends. Especially is this spirit necessary with persons in key positions who come in constant contact with the public—nurses, interns, information clerks, and telephone operators.

It is imperative that every hospital administrator and all personnel within the hospital should fully realize that by their works they shall be known, that community relations must be lived day by day, and that little attentions to patients, their families and friends, can be productive of big results in community esteem for the institution.

There is no easy or quick road to the establishment of community good will. The building up of a good reputation for the hospital requires constant effort both within the hospital itself and in the community outside. All efforts such as educational publicity, press articles, radio broadcasts, and talks before lay groups are of the greatest importance; but within the hospital itself, we must be on the alert to practice constantly what we preach. Make every day *Hospital Day* in your institution and put your best foot forward 365 days in the year, as you do on the one day specially set aside for hospital visits and inspection. To summarize:

1. The administrator must regard himself as an ambassador of good will for his hospital.
2. The administrator should make patients' rounds, and as far as possible know the patients in his hospital.
3. Cultivate a staff who are considerate and attentive to visitors and friends of patients.
4. Make every day "Hospital Day" in your institution.

The 1950 Annual Reports of the American Hospital Association show that over 7,000 hospital people have attended the 82 institutes held since their inception in 1944.

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Fission Chips

(Concluded from page 33)

How to Organize

In addition to the normal number of sick a huge casualty list is to be expected. Public health officials will need help in the maintenance of sanitation and other welfare services. Hospital facilities, physical facilities, casualty aid and clearing stations, and mobile units must be provided. Transportation will be needed for thousands of patients, volunteer workers, and supplies. In many cases this will be over areas presenting unanticipated difficulties and lacking any facilities previously found there. Furthermore, we will need to procure and stock-pile equipment, food, and medical supplies beyond anything formerly attempted.

All this means that every person in a community must be trained and educated in first aid, self help, and home care. No group can work alone. Therefore, all existing services, voluntary, municipal, provincial, and federal, must unite to work out a program of defence.

A complete inventory of all hospitals, nursing homes, government, and other buildings which could provide shelter, is essential. Along with this, areas should be chosen which would be suitable for the erection of temporary hospital buildings and numerous casualty clearing stations. To accompany this inventory, an active file will be necessary to list all physicians, dentists, nurses, Red Cross, St. John Amublance, and hospital workers, with a summary of their capabilities.

In every community one person or group of persons should be chosen for intensive and specialized training in atomic medicine and civil defence. These people, upon return to their districts, may then instruct others and introduce the planning methods which they have studied. Instructions can be given to the non-professional citizen and a roster prepared to list stretcher bearers, runners, transportation workers, and first aid men. These, with the professional people, will make up the casualty teams. Everybody will have something to do; defence in this type of disaster will need the services of every citizen.

Conclusion

Clear thinking and organized action can control some of the disaster resulting from an atom bomb attack, but the hydrogen bomb would perhaps be different if its full potential were developed. A dictator, faced with certain defeat, would have it in his power to drag down much of the world with him. No one can deny that this is a possibility which might arise some time or somewhere. The hydrogen bomb presents a real threat to the survival of the human race.

The Servant of — ?

The doctor is the servant of the patient
When the doctor is the master of his fate.
But the patient is the servant of the doctor
When the doctor is the servant of the state.

With the Auxiliaries

(Concluded from page 60)

New Hospital Aid Shows Rapid Progress

The treasurer's report at a recent meeting of the Pilot Mound Hospital Aid, Pilot Mound, Man., showed over $500 in cash receipts since its organization. This new group has 129 members with two life memberships. The president was appointed as a delegate to the hospital aid convention which was held October 20, at Winnipeg.

* * * *

Auxiliary Shops for Patients

The fall activities of the Lennoxville Wing of the Auxiliary at the Sherbrooke Hospital, Sherbrooke, P.Q., are now under way. The ladies of this branch auxiliary are now canvassing for funds for the hospital and have also offered to act as shoppers for any patient desiring that service. Plans are being made to compile a cook book for sale to the public.

Auxiliary Helps Furnish Children's Ward

Five hundred dollars were donated recently by the Ladies' Auxiliary of the Payzant Memorial Hospital, Windsor, N.S. This will be used to help furnish the children's ward of the new wing of the hospital. The auxiliary also plans to purchase a dolly for use in the operating room.

* * * *

Physicians' Wives' Association Sets Year's Objective

When the new nursery wing at the Toronto East General and Orthopaedic Hospital opens next spring it will be well supplied. This is largely due to the efforts of 125 wives of staff and visiting doctors who have raised nearly $8,000 toward its equipment. For the past year more than 50 members have devoted one full day each week to making layettes. The objective is a year's supply. The ladies now have 1,200 articles which represent an eight-months' supply. This association, which has been in operation for over 20 years, has raised more than $20,000 during that time. Their funds have been obtained by holding bazaars, raffles, bridges, and teas. The latest money-raising venture was a tea held at the end of October.

* * * *

Busy New Aid at Carrot River, Sask.

The hospital aid for the new hospital at Carrot River, Sask., plans to spend $1,000 on equipment. Included in the purchases will be an operating table, lamp, soap dispenser, basin rack, and instrument table for the operating room. Seventeen woollen blankets have been given to the hospital. They were made from donated woollen articles which were converted into blankets by the woollen mills. Three mats for the nurses' home are now being made in the same way. This group now has a total of 42 members.

Want and For Sale Advertisements

WANTED— EXPERIENCED DIETITIAN

St. John's Convalescent Hospital, Newtonbrook, Ont., requires experienced dietitian to take charge of Dietary Department of hospital. Residence provided if desired. Apply to Superintendent. Phone MOhawk 3578.

WANTED: SUPERINTENDENT OF NURSES

53-bed hospital requires the services of a qualified Superintendent of Nurses as soon as possible. Good living accommodation. Training school will be opened shortly; building programme to build a new 85-bed hospital under way. Apply stating qualifications, experience, references and salary expected to: The Administrator, All Saints' Hospital, Springhill, N.S.

BUSINESS ADMINISTRATOR WANTED

for Highland View Hospital, Amherst, N.S., Business Administrator. Apply in own handwriting, giving qualifications, age, references and salary expected, to: Secretary Board of Commissioners, High View Hospital, P.O. Box 396, Amherst, Nova Scotia.

DIRECTOR OF NURSING

Applications will be received by the undersigned for the position of Director of Nursing of the Saskatoon City Hospital, a 350-bed General Hospital. Duties will include those of the Principal of the School of Nursing. Position open January 1, 1951. L. T. Muirhead, General Superintendent.

WANTED REGISTERED MEDICAL RECORD LIBRARIAN

The Kingston General Hospital (Medical Teaching Hospital for Queen's Medical School) has an opening for a registered Record Librarian in the Senior position. The authorized staff consists of three registered librarians and three assistants, including medical stenographer.

In addition to the Senior opening, the present staff is being enlarged for one assistant. The present Librarian in charge is leaving Kingston for reasons beyond her control, but will be available to work with the new officials for several weeks.

Substantial salaries are available. The Department is in a going administrative condition. Address inquiries to R. Fraser Armstrong, Superintendent, Kingston General Hospital.

WANTED— GENERAL DUTY NURSES

for 220-bed General Hospital. For further particulars write to: Miss M. E. Jackson, R.N., Supt. of Nurses, Brandon, Manitoba.

WANTED—CHIEF DIETITIAN

for 180-bed Children's Hospital. Apply stating qualifications, age, experience and salary expected, to Miss E. Andison, Box 96, Station H., Montreal, Que.

AUTOCLAVE FOR SALE

Prometheus Electric Automatic Dressing Autoclave on stand 16 x 30; 220 and 120 volts; gauges for low and high pressures. Dr. H. Levson, 3191 Crown St., Vancouver, B.C.

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for training School for Nurses, general duty Graduate nurses and dietitian required for a modern 100-bed hospital in a central Manitoba town of 6,000 population. Eight hour duty, one month's vacation after 1 year's employment, Blue Cross Plan available, good salary with full maintenance. Apply, stating qualifications, experience and salary expected to the Superintendent, Dauphin General Hospital, Dauphin, Man.

Index of Advertisers

NOVEMBER, 1950

CCAB

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Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published monthly by The Canadian Hospital Council, 57 Bloor Street West, Toronto 5.

BNA